THE GOVERNOR'S CONFERENCE ON MENTAL HEALTH

Earl Warren
Governor of California

SACRAMENTO, CALIFORNIA
March 3 and 4, 1949

Final Report

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President, California Institute of Technology
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FOREWORD

The mounting toll of mental breakdown in California had become a matter of such public concern that I felt it wise to call a working conference to evaluate existing mental health programs and work out future plans.

The Conference marked the emergence of a more unified approach in our thinking on mental health and served to focus public interest on this too-long neglected health problem. Never before in the history of the State had such a broad, representative group interested in this problem come together to deliberate on a statewide program.

A preliminary report of the section findings and recommendations was published and distributed to interested individuals and groups as soon as possible following the Conference.

This final report contains the texts of the principal addresses, a summary of the discussion in the nine sections which reflect the various shades of thought—points of disagreement as well as agreement, and the recommendations. Because of lack of time, it was not possible for the Conference to harmonize the section recommendations and no attempt has been made to do so in this report. This will be done by the Continuing Committee.

The Chairman of the Conference, Dr. Lee A. DuBridge, at the closing session recommended not only that the proceedings of the Conference be published but also that a continuing committee be appointed to bring the recommendations of the Conference to the attention of state and local authorities for the purpose of implementing them. This was also the spontaneous suggestion of several sections of the Conference. At my request, Dr. DuBridge selected a representative group of men and women, of which Dr. A. S. Raubenheimer is Chairman, and they have already undertaken their work.

With the foundation for future action thus laid, the opportunity is now provided to work together for the realization of a better program of mental health in California.

Earl Warren

Governor of California

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OPENING MESSAGE

The Honorable Earl Warren
Governor of California

I welcome you to Sacramento for what gives promise of being an historic gathering. As far as I am informed this is the first of its kind to have been held in California. And certainly you who have responded to my invitation are sufficiently qualified from the standpoints of both knowledge and public interest to light the path which your state government should follow in the performance of its very important and solemn duty of protecting the mental health of its citizens.

We have had many conferences in California recently at which we have taken inventory of our state assets and liabilities and have attempted to appraise our problems of the future in many fields of activity. These have covered the fields of youth, crime, recreation, water resources, etc. All of these were fundamental to the life of our State, but certainly none of them more fundamental or important than the cause that brings us together today.

I believe this is a propitious time for such conferences. We are fast rounding out the first hundred years of our state history. On this date a hundred years ago there were not more than fifteen or twenty thousand people exclusive of native Indians, in all of what is now California. But during the remainder of that year tens of thousands of people came across the plains and mountains in ox-drawn covered wagons, or around Cape Horn in clipper ships, in a mad scramble for the gold that had been discovered only a few miles from this spot. The next year, 1850, we blossomed full grown into statehood. From wilderness to statehood in a matter of months it was necessary to quickly establish all the services of government. In the following year, 1851, the Legislature took cognizance of our mental health problem by establishing a state hospital at Stockton. It was called an insane asylum. One of the significant facts about this new institution was that when it opened its doors it had a hundred patients, but only eighty beds. Since that time conditions at Stockton and our subsequently established hospitals have been very much the same; always with more patients than beds, until now our excess population runs into thousands.

It is to relieve this congestion and to take our hospitals forever out of the asylum class that brings us here today.

You have been generous to leave your important duties to come here, but I am sure that there will be lasting satisfaction for all who contribute to our efforts.

There is one person who is not here, however, who should be here and would be here except for the fact that she is in a local hospital fighting to regain her health after a serious operation. Most of you know her. She has devoted herself the last six years, under very great difficulties, to taking our institutions out of the asylum class and making them real hospitals for the

treatment and care of our mentally ill. Throughout that time she has been hampered by congestion in obsolete and often dangerous hospital buildings. During the war and for most of the time since she has been unable to recruit a sufficient number of doctors, nurses, or even attendants for the service. At the present moment we have positions for 35 doctors and more than a hundred nurses that cannot be filled because of shortages in both professions. It was not until recently that we could go full speed ahead on construction, and even now many of our new beds merely replace others that have been in obsolete buildings which must be closed.

But Mrs. Heffner has done a faithful job. She has given the best that was in her under trying circumstances even to the point of injuring her health.

I desire to read you a letter which I received from her yesterday. I do so with sadness, but with appreciation for the years she has served with me:

> "I regret that I am unable to attend the Conference on Mental Health that we planned together. Illness prevents me from doing so.
>
> "The Conference means a great deal to the cause of mental hygiene in California. Many of the persons who have accepted invitations to participate in it have been helpful in developing a program for this State and I am deeply grateful to all of them. For me the Conference rounds out six years of struggle to improve the lot of the mentally ill in this State, but the work is not finished and it must go on.
>
> "I am no longer physically able to give to it the attention that it deserves, and for this reason I feel that if I stay on progress will be retarded. This is the last thing I would want to happen. I, therefore, ask you to accept my resignation as Director of Mental Hygiene, effective at your pleasure."

I am sure that Mrs. Heffner has the good wishes of all present in her efforts to regain her health. I know that she will always be interested in some humanitarian cause.

Members of the Conference, we are dealing with a new science; one that has only scratched the surface, but which has greater potentialities for good than any of the great sciences. It can do more to bring order out of chaos and bring happiness to humankind than the others. But we know comparatively little about it.

The best minds of history have devoted themselves to the study of human nature, but because it could not be approached from a scientific standpoint, little progress was made. Pinel and Rush and Dix all made progress in former centuries, but the science of psychiatry has actually been developed in the last 50 years. I shall not attempt to discuss it now. The time that would be taken up by doing so can be used to much better advantage through an exchange of information between you who are devoting yourselves to the advancement of mental health.

It is sufficient for me to point out that mental health is the number one health program of the Nation. We have over a half million patients in mental hospitals, almost as many as for all other causes combined. It is estimated that at least eight million of our people are affected with some mental disorder. We

know that one out of every eight boys examined in the draft during World War II was rejected because of some mental defect, and that 50 percent of all the rejections from the service were for that cause.

We have 37,000 patients in our state hospitals, all wards of the State, helpless, unfortunate wards. There are hundreds of thousands who are in need of mental hygiene. We believe that a large percentage of these can be cured through proper medical care in modern hospitals and clinics. We recognize that our hospitals do not yet reach the high standards that common humanity and good business call for. But we are determined that they shall reach these standards as soon as possible.

It is to accelerate such a program that I have called you together today. We expect you to be frank about existing conditions and objective in your approach to our problems. I know you will be earnest in everything you do.

You have my best wishes for a successful conference and you may be sure that I will do my best as Governor of our State to make our mental health facilities the humane and curative institutions they should be in an enlightened State like California.

GREETINGS

By the Honorable Phil S. Gibson
Chief Justice of the Supreme Court of the State of California

The judiciary of this State is vitally interested in the problems that are to be considered at this Conference. Most illnesses are primarily and perhaps exclusively medical problems, either preventive or remedial. In cases of mental illnesses, however, law and medicine must combine their resources in providing for the welfare of the patient and the protection of society.

In the early history of the country, the law was only slightly interested in an insane person unless he had property; or, perhaps it would be more correct to say that the law was interested chiefly in the property of an insane person.

Until comparatively recent times the plight of the mentally incompetent was a matter of public concern only to the extent necessary to administer or control his estate. The indigent insane were treated as common criminals or unwanted paupers. You of course are all familiar with the tragic record of the treatment of persons who were mentally ill in colonial times. They were regarded as subhuman; they were placed in chains, confined in kennels and cages like beasts, or were incarcerated in dungeons, or driven from town to town, starved and naked.

We have undoubtedly made considerable improvement in the care and treatment of the mentally ill, but there is still a great deal to be done, and some part of that task is within the sphere of the legal profession and the judiciary.

The courts are interested in these problems because upon them rests the responsibility of determining when a person is so mentally ill that he cannot enter into valid legal transactions, cannot control or dispose of his property, and, what is much more important, must suffer confinement in an institution. This determination necessarily results in the loss of fundamental civil rights, and the decision weighs heavily upon the conscience of every judge.

In Los Angeles County alone in 1948 there were more than 5,000 persons who were parties to commitment proceedings in the superior court. In these proceedings the courts are, fortunately, able to call upon the services of trained experts, but sometimes they do not select the best qualified men to aid them, and sometimes the best qualified men are not available in the particular locality.

In recent years considerable progress has been made in commitment procedures. But there is still much more that can be done to improve our methods. These matters could be handled more expeditiously and more economically, and with less attendant anguish to the patient and to his family. In this regard, it is my plan that the Judicial Council of California, which is charged by our Constitution with the responsibility of making recommendations to the Legislature and to the Governor in matters relating to the improvement of the

administration of justice, will cooperate with this Conference in devising better methods for hospital admission.

There is another problem to be considered at this Conference in which the courts are vitally interested, namely, the treatment of alcoholism. I believe that it is wrong to punish a man because he is sick, even though his illness may be a result in part of his own misconduct. I believe the time will come, and perhaps that time is not far distant, when we will look back on some of our present methods of dealing with alcoholics as cruel and inhuman, just as we now consider abhorrent the punishment which was meted out 200 years ago to those poor unfortunate women whom our forefathers in New England called "witches."

We are very grateful to you, Governor, for calling this Conference and giving us an opportunity to discuss these problems. We are likewise deeply indebted to the Press of this State for the informative articles and splendid editorials which have recently been written on this subject. I am sure that we will leave here with renewed hope that a vigorous attack on these problems will bring us closer to a progressive and humanitarian solution.

OUR MENTAL HOSPITALS—THEIR POSSIBILITIES AND DEFICIENCIES

Winfred Overholser, M.D.
Superintendent, St. Elizabeth's Hospital, Washington, D. C.

It is not a new thing for the State of California to be interested in the mental health problem. Only recently I have had the occasion to read an interesting document published by the State in 1871. At that time the Stockton State Hospital, as it is now known, had been growing up to the huge size of a thousand patients, and it appeared necessary to establish at least one other state hospital, the State having become almost a half million in population.

So the State of California commissioned a physician, one Dr. E. T. Wilkins, to visit the existing mental hospitals in this country, in Canada, in Western Europe, and in the British Isles. He was a most industrious person; he visited 150 of them! He wrote an excellent report on the status of mental hospitals in planning and operation, in what was then looked upon as the civilized world. It is interesting that he visited Stockton much and became informed of its good features and glaring defects. He was willing to concede that there were good features. There are a fair number of newspaper writers who are still willing to concede that where there are glaring defects there may be good features too!

The State of California has grown beyond the wildest dreams. If anybody 85 years ago had said that in 85 years this State would have 10,000,000 people he would have been considered a candidate for Stockton!

Times have changed tremendously. But it is interesting that the attention of the public, under the splendid leadership of Governor Warren, has become focused upon the problem again, because history shows that the spotlight has shifted. There have been times before when a very vigorous campaign to improve the lot of the mentally ill was carried on—Dorothea Dix, for example, in the middle of the last century.

The public has a way, unfortunately, of getting very much concerned and doing something and then letting things slide for a while. The spotlight does not usually stay focused on one subject. I think, however, that the spotlight is going to stay focused for a good while on the subject of mental disorders, because it has come out of the shadows and is recognized as a medical problem. From now on the public is not going to rest and let these institutions moulder in the outskirts of civilization.

Now, if California has developed and if the state hospitals have developed, so has psychiatry, and so have the facts about the treatment and prevention of mental disorder been unearthed. I do not mean all of them. No, there are really very few psychiatrists who think they have all the answers, but there are many things that we did not have the faintest conception of 30 years ago that we do know now.

One of the things that has hampered the development of mental hospitals is that originally they were looked upon as welfare, not medical, institutions. Psychiatry was pretty much, in the early days, outside of the field of medicine. Actually until the time of Pinel in 1790 the care of the mentally ill was not a subject of concern by the medical people at all. What writing was done about it, what talking was done about it, and what treatment was done was done by philosophers and by the clergy, not by medical men. In this country, the institutions that were set up had as their interest, as the Chief Justice said to you a bit earlier, the furiously mad, as they called them. They were not interested in these people as medical problems; they were interested in them as menaces to the public peace or public complacency. That trend has continued for a long time—actually I think that even today there are not more than a half dozen states in which the administration and control of the mental institutions of the state is vested in a medical department, headed by a psychiatrist. For a long time New York and Massachusetts were the only ones.

In a great many states the tendency has been to have a board of control or a board of institutions. In such departments, in which the aspect of charity was the outstanding thing, comparison of costs was made—not with hospitals or sanatoria but with the state infirmary and the almshouses, the poorhouses, or whatever they might be called. As a result, legislatures have tended to have a somewhat perverted point of view from this fact alone. The budget would come up for institutions caring for mental patients, but it was not looked upon as one for a hospital. As a result, the budget was thought to be too large and the well-known "pruning hook" went into operation.

Then, too, another factor is that in the earlier days these institutions were geographically isolated and were removed some distance from centers of population. Travel was difficult then. The public could easily forget them away out in the country. There was, too, a spiritual isolation, if we may call it that. The doctors were looked upon askance, as perhaps not even eligible for local medical societies, as not equal to the rest of the medical men. The whole specialty was a very isolated one. There was no stimulation or give and take on the part of either the profession or the public to see what was going on.

We have, then, historically some reasons why it has been just a bit too easy to fail to give these institutions the continual support that they should have, as to maintenance, as to personnel, and as to space for the patients.

Overcrowding is not peculiar to California. Indeed, I do not know of any state where there is none. Some of this can very properly be blamed upon the war, of course, because for a period of nearly 10 years there was very little opportunity to do any building.

But the public attitude has changed. Today we find an interest on the part of the public in the people who are mentally ill. I think that the war had a great deal to do with that. Sometimes some good things come out of a war. One of them was the wide diffusion of information among the public about the nature of mental disorders, major or minor. The public began to learn that a great many people may have temporary disorders, some of them quite disabling, but which respond to treatment.

There is certainly not a community in which there were not one or two boys who went into the service and had some sort of a temporary breakdown but came out essentially well. "That happened to this boy. We knew him before. He was in pretty good condition and yet put under great stress, he broke." The public hardly realized this before. The public is getting more and more interested in emotional disturbances. There have been many articles and books written, there have been movies, some of them good, some of them not so good, dealing with this topic. There is a wide interest, certainly.

I am not sure that the psychiatrists fully appreciate how much interest there is among the general public and how much information, and how much of that information now is moderately accurate. That was not true some years ago. There probably has never been a topic on which there has been so much misinformation.

What happens when you get crowding in a mental hospital? Why worry about crowding, you say? Actually from the point of view of the orderly administration, for the proper care of the patient, adequate space is pretty important. When you get patients rubbing elbows unduly close you are going to have more altercations, injuries to the patients. You will have poor hygiene. You are going to have a greater incidence of respiratory infections, of tuberculosis which used to be the bane of the hospitals. It used to be practically the leading cause of death in mental hospitals. Today a great deal of progress has been made, but crowding is one of the conditions which makes for increased infections.

Then, too, when you have overcrowding there is a tendency to hold back admissions, to put pressure on the courts, to refuse voluntary patients. Of course you have a voluntary law here, as every state should have—only five states do not. With crowding, patients are refused admission when they ought to be admitted. That means that you will have an increase in suicides, in disorderly conduct of one sort or another, discouragement on the part of the family, and a lot of other repercussions. The public then becomes discouraged and says, "Why, what's the matter? Why don't they let these patients go to the hospital when we want them to go, when they need to go?" And then they begin to murmur and feel that there is a good deal of improper conduct, even a lack of efficiency, on the part of the State.

I do not know that it is directly due to overcrowding—there are probably other factors—but California has a low ratio of patients in mental hospitals. Actually it has half the rate that the District of Columbia or New York or Massachusetts has. I do not think that that is due primarily to overcrowding. Partly, you have a younger population, but, if my information from the papers in the East is correct, there is a very substantial amount of immigration of people over the age of 65. Even though California is a young state it is getting old fast. You see, you do not always have to wait for people to get old, when they move around already aged to start with. You do not have to age them in California.

There is one thing that we do know. That is, that the older the population gets, the greater the incidence of mental disorders becomes. It is primarily a disorder due to the aging process. It is far higher, let us say, past age

60 than it is at age 20. Actually, statistically you can show that a person of 20 years has one-tenth of a chance of getting in a hospital that a person aged 70 has.

We may expect in the future a number of things. We may expect a constant pressure for patients to be sent to the hospital. It is likely that a fair number will not be very responsive to treatment because they are suffering from degenerative conditions. That is one of the penalties that we have to pay for having preventive medicine.

It is quite necessary to bring the capacity of your institutions up to a reasonable working basis as rapidly as possible.

Of course, some institutions are in poor condition. Undoubtedly some of them were poorly built. Some of the early buildings, however, were put up extraordinarily well. The original building of St. Elizabeth's is 100 years old, but it was put up so soundly and securely and so comfortably and it is so practical, that actually this year we are putting in an elevator. The mere fact that a building is old does not mean that it should be junked. We have some fairly recent buildings that I can hardly wait to tear down because they were poorly planned and poorly constructed. Mere age does not mean necessarily that a building is obsolete. Undoubtedly there are other factors involved, such as danger of fire, which ought to be corrected, and I am sure that a considerable number of your state hospital buildings are on the way out as soon as replacements can be provided.

Now, if the number of patients has increased, and it has, certainly the possibilities of treatment have likewise increased.

What goes on in the hospital? The treatment of general paralysis has been revolutionized since 1922 in this country. The first malarial injection was given in St. Elizabeth's in that year. We can say that in most of the cases we can check the disorder and we can send the patient out, depending upon how early we got him, essentially recovered, and have him go back to work. That is one respect in which there has been an astounding change or progress of treatment.

We have learned a great deal about the role of vitamins, alcoholic psychoses, and the conditions of senility. We have found that many conditions that we thought were due solely to senility are due primarily to inadequate vitamins.

The various so-called shock treatments have been accepted with undue enthusiasm. They have a place, however, and in certain types of disorders prove effective, permitting an early discharge.

There has been an increasing attention to physical disorders causing mental symptoms. We have learned a great many things about the physical basis of some mental symptoms.

We have learned that many things can be done in the early treatment, man-to-man treatment, the contact between the therapist and the patient, sometimes individually, sometimes in groups. This we refer to as psychotherapy. A great deal is being done in group therapy. That is a practical thing because you can multiply your doctor. He can deal with 25 patients at once, and the patients deal with each other. The patient may express some fantastic

paranoid delusion and will accept the possibility of its falseness if some other patient tells him it is a delusion.

Activities along the lines of recreation, art, music, painting, and dancing, both ballroom and rhythmic, are very helpful therapeutically.

The development of psychiatric nursing is proceeding. In the District of Columbia no nurse is admitted to examination by the Nurse Examining Board who has not had at least three months of her training in a mental hospital. There are other states who are ready to take up that program as soon as training facilities in hospitals become available.

Clinical psychiatry has developed; dietetics and occupational therapy have developed tremendously. These all involve people, trained personnel too. Even the attendant, who is in many ways the backbone of your mental hospital, can do much more for the patient if he has had some training. In a good many places he is given training, as he should be, to make him a more useful worker.

We know that a great deal can be done early for patients if the facilities are there.

There has been a tendency to have temporary hospitals, psychopathic hospitals, and I see that that is one of the parts of the program.

In 1871, to go back to California history, the State Board of Health in their Second Annual Report recommended what they called "Probationary Asylums." The writer said, "Give insanity no foothold." They were talking in terms of psychiatric units in 1871. Let us give the founding fathers some credit for quite a bit of wisdom. A lot of these things took a long time to accomplish.

The important thing is personnel. And, if you have to take the choice between the two, as I hope no one will have to do, I should say by all means focus on personnel, because you can conceivably do some kind of a job if you have ample personnel in a building that is not ideal, but if you have the fanciest pile of bricks and mortar and you do not have the people who know what to do with the patients, you can accomplish nothing.

What does understaffing do? Suppose you do not have enough people. You are going to have more physical restraint. You will keep the patients locked up in the wards with no activity outside, and if they give you the slightest disturbance they are going to be locked in a room, or they are going to have some sort of mechanical restraint applied—some of those curious things that have come down from the middle ages, "straightjackets."

If you have not enough people to treat your patients, you are going to lower your discharge record. Patients may be in a condition to go out, but the doctor just passes them over. If the family does not press for discharge, they stay.

You will be under pressure to employ unqualified people, and sometimes they can do more damage than good. You will have the serious likelihood of overlooking remedial physical conditions in your patients. That is quite likely. Where a doctor has two or three hundred patients under his charge, how can he have a chance to make physical examinations? How can he know whether this patient has something that ought to be dealt with?

You will have discouragement of the staff and the rest of the personnel. It will be harder to hold them and get them replaced, and then as you lose them you are understaffing more seriously. Your patients are neglected, your staff unhappy—a vicious circle.

So much for the inside of the hospital. What about the outside? When the patient is in condition to leave? I am convinced that the patient should be in contact with the social worker while he is in the hospital and when he leaves the hospital. That is a good thing for the patient. He feels the support of the hospital. It is a good thing for the family to know that the hospital is still interested, and it has an educational effect upon the neighbors of the patient to know that the hospital is interested in him, trying to keep him out and trying to keep him afloat in the community, but ready to give him shelter again if he needs it.

Outpatient clinics of the hospital are important for the public and good educationally for the doctors. Now that the Veterans Administration has put the facilities all around, you find the public ready to use them.

Of course, there is no ideal hospital. Nothing is ideal. Whenever anyone thinks that he has an ideal situation, he had better consult a physician and see whether he needs a psychiatrist or an undertaker. It is a part of life that things are not ideal, but there are ideals that we aim for and there are certain standards that have been set up which are not reachable at the moment but which are worth being aimed at.

The hospital ought to give prompt and effective treatment to the patient. It ought to get him out as fast as his condition warrants. If he is not in condition to leave the hospital he should be treated for whatever is the difficulty.

As for his physical care, there should be a general hospital within the walls of a mental hospital, so that anything in the surgical or medical line will be handled by people who are expert in that field. I do not mean to make a surgeon of the psychiatrist. There should be a surgeon on the staff, or competent consultants from the vicinity.

There should be competent nursing service. There is one field that needs very considerable development.

The public should be educated. Preventive activity should be carried on by the hospital and the personnel should be trained.

There is a serious shortage of personnel in the various fields that I have mentioned.

Recently there has been a tendency to decry the state hospital as a training center. With the vast development of extramural psychiatry a good many psychiatrists who see the lure of gold in the distance are tempted and in the rush feel that they can get adequate training without serving in a mental hospital. The value of the mental hospital as a training center has been greatly underestimated. William James recognized it 50 years ago, and I think it will come to be recognized again. I hope it won't take 50 more years!

The possibilities as a career, too, are not to be underestimated. There are desirable features in institutional work just as there are undesirable ones. Medical students are going more and more to use mental hospitals as a part of their training; there is a very considerable arrangement of that sort going

on in this State. That will tend to bring the general practitioner to a realization of what psychiatry offers. A medical man or a social worker can profit more by knowing the mechanisms of human behavior. There must be an adequate start of training of these people. Thus again you come to a vicious circle of personnel.

There is a vast opportunity for research in these hospitals. I have indicated that there are a lot of things we do not know. There are many things to be investigated, and they should be investigated in the state hospitals.

Just by contrast, let me say that in this country, for every victim of infantile paralysis annually about $94 are raised for research and study activity. For every case of mental disorder developing during the year, if we are very generous in our estimates, we will find as much as $0.87 is spent for research. I suggest that something might be done to remedy that discrepancy. Certainly, it does not seem quite logical, does it?

I have perhaps said more than I should have about the deficiencies. There are deficiencies everywhere. There are possibilities, too.

There is a possibility that is certainly worth trying to achieve for the benefit of the patient, for the benefit of the public. It is a sound investment in the long run. It is not charity. It is not relief. It is simply a meeting of the needs that are being recognized by an awakening public conscience, by dealing adequately with people who need attention and care.

We might, if we were speaking to the people of California, as I hope we are, if we were speaking to the Legislature, as I hope we are, repeat Dorothea Lynde Dix's statement to the Massachusetts Legislature in 1843, more than a century ago. She said, "Gentlemen, I commit you to this sacred cause. Your action upon this subject will affect the present and future condition of hundreds and thousands."

PREVENTIVE MENTAL HEALTH SERVICES

Henry C. Schumacher, M.D.
Medical Director, U. S. Public Health Service

First of all, I wish to express my appreciation for this opportunity to speak to you today on the general topic of preventive mental health services. Historically there are three phases in the total mental health program. In his talk yesterday Dr. Overholser called attention to the fact that originally our institutions for the mentally ill were primarily custodial in nature. As time has gone on, and particularly as a result of the lessons learned in World War I and the ever-increasing interest in a more dynamic psychiatry, more and more attention has been paid to treatment—treatment both within the institution and in extramural clinics. It is our hope that, through early treatment, patients may not need to come into the institution.

As a result of knowledge gained, it has become increasingly clear that people need not necessarily become mentally ill, that mental illness is not a hereditary-biological process but that socio-emotional factors are causative of mental breakdowns. With this newer knowledge, more and more attention has been directed toward early treatment. The child guidance clinic movement is expressive of that fact.

And now we have entered into the third phase of the total mental health program. This phase has come to be called "preventive mental health." There is, of course, no sharp distinction between these three phases of a total program. A preventive mental health program aims at keeping something from happening that might otherwise happen. A preventive program might be defined to include not only the prevention of disability through early recognition and treatment, but the prevention of more serious disturbances and their spread to others. Prevention always implies some conception of the nature and cause of the problem.

We have learned much in recent years about normal growth and development, both from a physical and a psychological viewpoint. It is the aim of preventive programs to keep the individual so integrated that normal growth and development will at all times be possible; therefore, all advances in physical medicine and in psychology need to be considered as important in planning preventive programs.

We have already pointed out that it is difficult to separate out early treatment from true prevention. This afternoon, however, we want to stress the preventive aspects of a total mental health program, and we would like you to keep in mind that this does not mean that the other phases of such a program are now to be neglected. Rather we wish to stress this phase both because it is the assigned topic and because we believe that it is the most important phase of a total mental health program.

One could start almost anywhere in the total life cycle; however, for our purposes today, let us start with prenatal classes. All the newer knowledge

relating to the physical health of the pregnant woman and her care at labor is making a great contribution to mental health in that it gives the child every opportunity, from a physiological viewpoint, for normal growth and development. However, we are also aware that pregnancy for most women is of major emotional significance. Most women have heard tales of nausea and vomiting, of increasing discomfort with each month of pregnancy, of the pain of delivery, of changes in form and figure, etc.

All women also respond to the cultural demands of the times; for instance, to the meaning of children in our culture, the spacing of children and their proper rearing, etc. In other words, practically every pregnant woman has occasion to have anxieties, fears, and worries over her pregnancy and its meaning to her and her husband and its possible effects on other children. Well-conducted prenatal classes offer the pregnant woman an opportunity to discuss these fears, anxieties, and worries and to receive help. This means that we must pay particular attention to the mental health training of the doctors and nurses who work in these prenatal clinics and classes.

In passing it is well to point out that there are some 22,000 public health nurses in our country. Here is a tremendous group of individuals working with people—and those not necessarily sick people. This group does need more training in the meaning of attitudes and feelings and their effect on people. Certainly in the prenatal classes there is an excellent opportunity for sound mental health work which would help the pregnant woman accept her pregnancy, free from crippling emotions and fears. She would as a result, too, be more open to an acceptance of modern knowledge about the needs of the baby and the growing child. Had she not these crippling emotional states, she would be free to endure, to accept, and to act upon the three basic needs of every child: First, a need for food and shelter adequate for normal growth and development; second, a sense of security in the affection of its parents; and, third, a continuing sense of worthwhileness as an individual in its own right.

It should be possible, therefore, for all women to receive sound prenatal care in prenatal classes. Obstetricians are becoming increasingly aware of the value of such classes. They see the pregnant woman going into labor without tension and fear; they are finding that life is much more comfortable both for themselves and for their patients and that there is much less need for interference with normal delivery. Certainly physicians are paying much more attention to the emotional needs of their patients. Psychosomatic medicine, about which most of you are hearing much these days, is but another way of stating that doctors are aware that they deal with the total patient, which means that they deal also with the emotional needs of their patients.

Next comes the well-baby conference. Mothers are not expected to know all about growth and development. As a result, they do have questions about what is normal and what is abnormal. They do need help. This they can get in the well-baby conference, but, again, only if the personnel, that is to say, the doctors and nurses, both understand the needs of parents and have the time and training to discuss these needs with them, appreciating that the attitudes and feelings of the parents need to be dealt with.

Parents do have certain potentialities within themselves of being good parents. They need help in understanding how their own emotions frequently interfere with their doing a good job of being parents. They do need knowledge of normal growth and development. They do need to know that certain things are to be expected at certain times and are perfectly normal at that stage in the growth and development of the child. Because of their closeness to the child, they frequently misread the signs of normal development, on the one hand, or, on the other, note certain abnormalities which cause them great fear and anxiety. Their seemingly irrelevant questions are motivated by fear and anxiety as to what is normal or abnormal. This needs to be understood by those who are working with them in order that there be no undue pressures on the child, on the one hand, or a failure to correct interferences with normal growth and development, on the other hand.

We need constantly to keep in mind that there has been quite a cultural change in family life in the last several decades. We are in a period now where we speak about the *immediate* family rather than the *kinship* family. Years ago it was common to grow up in a community where one's relatives lived. We probably were children of fairly large families. There were aunts and uncles and grandparents. Then, too, there were close acquaintances of the family, many of whom, although they were not in the direct line of kinship, we called "aunt" and "uncle" because of their very nearness to the family. The child growing up under those conditions had need to adjust himself to many different adults. He knew that there would be different responses from different people to the same bit of behavior. There was a certain immunizing—if I may use that term—to various kinds of individual behavior. This was of great socializing value. The child came to understand the attitudes and feelings of others and to appreciate his own responses to such attitudes and feelings.

Today, however, there are but mother and father and perhaps another child. This, of necessity, brings about a closeness of relationship for all members of the family group. The parents have no one with whom they can share their anxieties, and the child must turn to them for all his emotional satisfactions. Unfortunately, too, at the very time that there has developed this closeness of family relationship—that is, the immediate family as contrasted with the kinship family—the family runs greater risk of breaking up, as witness our ever-increasing divorce rates and their traumatic effect upon children.

In our society today there is need to provide children with an opportunity for social experiences that will, in some sense, approximate those possible under the kinship family system. Children need to have this opportunity to relate themselves to many others so that they can learn what is permissible and what is not permissible in human relationships and, in so learning, retain a sense of personal worth and dignity and individuality. Some communities have seen the need for this, chiefly because the mothers have had to go to work, and so there were day-care centers established. Other communities, and particularly those in the upper socio-economic groups, have solved the problem to some extent through nursery schools. Now almost at once someone will say, "Ah, this is just another way in which to take away from the parents

the responsibility for the care of the children." That, of course, is not the object at all; and, furthermore, well-run nursery schools are keenly aware of this problem. Good nursery schools insist that the parent maintain a close contact. In many of them parents are offered an opportunity—and they are expected to avail themselves of it—not only to learn about the growth and development of their child, but to receive help with their problems growing out of the rearing of the child. In this way the values accruing to the child in his nursery-school experience are carried over into his home life.

That there was need of some such facility as the nursery school and day-care center was known even in the times when the kinship family pattern was still operating. This expressed itself then in the need for kindergartens. The kindergarten is a socializing experience for the child. Here he has an opportunity to relate himself to other children and to learn to share an adult, namely, the teacher, with them. It was recognized that this made for smoother relationships when the child entered the first grade. Thus the nursery school is, in a certain sense, an extension upward of the well-baby conference, on the one hand, and an extension downward of the kindergarten.

Every child coming to school must make tremendous adjustments in his way of relating himself to others, a fact that is particularly true in our culture today. This is frequently overlooked. It is sometimes erroneously believed that the child at school merely makes an adjustment to the act of learning academic materials. What is overlooked is that this is frequently seriously interfered with because of his poor emotional relationships with other children, with the teacher, or with both.

Every child on entering school must work out some sort of relationship with other children. A mentally healthy relationship demands that he find status and that he play such a role that he has at all times a sense of personal worth. Teachers, therefore, have great need to know about the attitudes and emotions of children and, even more, to know of their own attitudes and emotions toward their pupils. They need to understand why this child appeals to them and that one does not. They need to know their own feelings about a child from a minority group or one who lives on the wrong side of the tracks, for obviously their feelings will condition their relationship to the child. They need to realize that the child must make a tremendous transition from home to school. They need also to keep in mind that the child who moves from school to school must, of necessity, spend a great deal of his energy in working out his adjustments to other children. The teacher needs to understand that the child who puts all of his eggs into the one basket of intellectual attainment may be doing so because he has withdrawn from any further attempt to make normal social relationships with his own age group. She needs to know that the quiet, unassuming youngster—the good child—may be a very emotionally sick child. She needs to know that many of the aggressive outbursts on the part of the school child are but explosions due to emotional frustrations.

Both parents and teachers need constantly to keep in mind that each individual child has needs peculiarly his own and that he has his own potentialities for development. These differ from child to child. Rearing and education, to be successful, must take these facts into consideration. It is not

democratic to deal with all children alike. Many of them cannot profit by such action. We need continually to keep in mind that the child cannot profit from an educational experience if he is in emotional rebellion against it. It has been frequently said that the school is a contributing factor to delinquency and that, because of the failure to understand the child as an individual and to meet his needs, pressures are put upon him which bring about rebellious, aggressive behavior, on the one hand, or a withdrawal type of behavior, on the other hand.

More attention, also, must be paid to the needs of exceptional children—the dull child, the bright child, the physically handicapped child, and the child who comes to school for the first time already burdened with emotional problems. These children have great need to be understood and appreciated for what they are and to have a program mapped out to meet their special needs. There is great need, too, for better teacher selection, for more adequate training of the teacher, particularly in the field of normal growth and development and in mental hygiene principles, and for greater provision for inservice training. The teacher will then be more adequately prepared to teach children and not solely subject matter.

There is need in our schools, too, for greater provision for educational guidance and vocational counseling; but, above all, there is need for all of the school personnel—the principal, the teacher, the school psychologist, the school physician, and the school nurse—to work together to integrate their knowledge about the pupils. Today there is a tendency for these several individuals to work apart. Each defeats the contribution that he could make were he more aware of all the knowledge that the school has about the child—about his physical health, his intellectual abilities and special disabilities, his emotional state, the family situation, etc. There is great need for coordinating and integrating this information so that it can be used constructively. True, more school help is needed, but California has made quite good provision for this. Full use of all that is available is not being made however. Were there this pooled information available, many of the beginning deviations from normal development could be understood as to the causative factors and an early remedial program instituted.

Every school could have a guidance center if it were willing to take the time to bring together the principal, the teacher, the school nurse, the school physician, and the school psychologist. Such an integrated approach to the problem presented by a pupil would make it possible to understand this problem and to deal with it. Furthermore, the knowledge gained in studying children in this way would be of inestimable benefit for all children.

Greater provision, too, must be made for adolescents. Right now, as a result of the increase in unemployment, this is the age group which is finding it difficult to obtain real work opportunity. It should be kept in mind that many did not profit too greatly from their schooling and that, because of the role they play in our culture today, this age group is particularly vulnerable to emotional disturbance. Many of them have not achieved a sound acceptance of themselves as having personal worth. They feel unwanted and unsure of their future. Their failure now to obtain gainful employment in satisfying

work is frequently sufficiently traumatic to produce emotional disturbance. This very commonly expresses itself in delinquency, and undoubtedly the present increase in delinquency in the late teen-age group is expressive of this fact. Much more study must be given to the place of the adolescent in our society. Can we afford to keep him acting like a child when biologically he is ready to assume man's estate? Is there no other program than that of having him continue serving time in a school system that does not make adequate provision to meet his needs?

More attention, likewise, must be paid to the problems growing out of the job situation, that is, industrial relations. It is becoming more clear that many of the emotional disturbances in the labor force which express themselves in strikes and conflicts, do not grow out of the job experience so much as out of the total life experiences of the individual. It is true that many jobs offer little that is satisfying to the creative energy of the workman; however, were there more adequate provision for after-hour satisfactions, this could be minimized. To be sure, there is need to give the workman a greater sense of worthwhileness on the job, to have him become more a part of the industry and not just a cog in the industrial wheel. This problem is being attacked in that many industries are building up health departments, and here, as in all fields of health, much more attention is being given to the emotional aspects of the problems brought to the attention of the staff.

I have already commented on the changing family scene, which of course is but a part of our total changing cultural scene. As a result of these changes in the family, there is more need for premarital and marital counseling. This type of activity has become a very important one in a preventive mental health service program. Skill and training are needed by those who venture into this field of activity.

This country has seen a great increase in population in the last several decades. Thought needs to be given to the question of what our people are going to do in order to live happily and harmoniously. At the present time jobs are still quite plentiful, and the problem of unemployment is not a troublesome one. Should there be a recession, however, we must consider at once not only the monetary needs of the unemployed, but their emotional needs as well.

As the labor market slackens, the older individual finds himself without a job. Careful thought and study must be given to this problem. It just does not make sense to have people without adequate provision for from, let us say, 45 to 65 years of age and then to give them old-age assistance. In that interval tremendous personality disturbances may ensue, and these are not remedied merely by providing more adequate assistance at 60 or 65. It is also important that thought be given to the problem of retirement. Is it a sound policy to have people retire at a certain given age? Must they be made idle and unproductive just because they arrive at a certain age, without any regard to their general well-being? What can be done to give the average individual hobbies, skills, or work opportunities that will prevent his life from becoming a humdrum existence after he is no longer gainfully employed? What provision can

a community make for the care of these older individuals within their own community?

Our mental hospitals today are showing a great increase in the number of older people admitted. It is quite possible that, had there been better provision for the emotional health of these individuals over the years, many of them would never have broken down. Then, too, we need to keep in mind, in thinking about the older individual, that the biological changes, plus the fears and worries over the future, often bring about nutritional disturbance. This nutritional disturbance is, in many instances, the basic cause for the acute mental episode. Unfortunately when this individual is now sent to a mental hospital, it is as likely as not that he almost at once finds himself on the chronic wards where there is a minimum of treatment and where no special attention is directed to his dietary needs. The end result is that his nutrition suffers even more and he goes downhill mentally even faster.

Communities can make provision for many of these older individuals. Housekeeper service can be provided; visiting nurses and public health nurses can be employed to give some of the care that is needed. The prevention of chronic diseases and the more adequate medical care of these older people will prevent, or at least alleviate, their mental decline as it expresses itself in psychotic states.

A preventive mental health program, therefore, must be geared to meet the needs of the individual from prenatal days to old age. Its primary program will be directed toward keeping the normal growth and developmental processes operating to the greatest extent possible. Secondly, it will heed the earliest signs of distress, as shown in any form of emotional disturbance, and will be prepared to institute at once a re-educative and treatment program.

In all of this I have said little about the work of the social agencies. They must not be left out. Adoption agencies, family agencies, and child welfare agencies all play a most important role. Everything possible should be done to strengthen these agencies. Such agencies serve not only the economically underprivileged but have great value in all situations, regardless of the socio-economic status of the individuals involved. School social workers and court social workers are urgently needed. More, too, can be done by the social workers employed in the convalescent mental-patient care programs. If these workers were increased in number so that each worker would not be responsible for so many patients, they could be used in preventive programs to a much greater extent.

It needs to be constantly kept in mind that many activities go into the rehabilitation of the convalescent patient. Family care, his acceptance into the community, his finding a job and being understood by his fellow workers, are some few of the needs of the patient. These the convalescent-care social worker must meet, but, in addition, these workers are often asked to interest themselves in early problems in the home and the school. They should have freedom and time to do so. In many of our communities they are the only trained people available. Too, they should be free to help the community study itself in order that it may provide the services needed for preventive and early-treatment work.

The essence of a mental health program is the use of every resource available in the community for the prevention and alleviation of emotional disturbances on the part of all the people in the community. The first important need is to study the resources. What has the community already? How can it improve what it has? How can greater cooperation and integration of the resources available be brought about? Obviously this implies a very close working relationship between health, welfare, and educational agencies. The strengthening of one strengthens the others.

CLOSING REMARKS

The Honorable Earl Warren
Governor of California

This Conference has been a thrilling experience. A governor's job is filled with long days and nights of hard work, some of which are very trying, but, once in a while, something happens that gives a great inspiration and a great uplift. This Conference has been one of those high moments in the life of a governor.

The response at this Conference has been phenomenal. There are more than 800 who have registered, and have faithfully attended and worked throughout these two days. They have come from all over our State on short notice, and have dropped important assignments in order to do so. There is not a casual onlooker nor a curiosity seeker in the whole Conference. Every person here has a deep interest in the mental health of the people of our State and many are devoting their professional lives to building it. It is impossible to get this many people together for a serious purpose without some lasting good coming from it.

I was delighted by the talk of Dr. Schumacher because it was a talk of hope. He gave me the inspiration to believe that, as a State, we can do much to prevent people from coming into our institutions. We want to have a people with sound mental health. He has shown us that there is much that we can do as citizens and as public officials to promote it, and that there is much we can do with the facilities we already have.

Because of the changes that have come into our society in California since 1940, this is a very important time to have this Conference and to look forward to the future. Until then, we had a basically agricultural economy. Now we also have an industrial economy that compares with the most industrialized states of the Union. We have approximately one-half million farm employees, and also a million employees in manufacturing alone, a large percentage of whom have come since the war. We have another two million who are engaged in trades and services. As our economy has changed, the lives of our people have changed and will continue to change. It is common experience that as communities and states become industrialized and more urbanized, there is a higher incidence of mental disorders. In this centennial period, we are also recalling the days of our beginning as a state and contemplating the hundred years of progress we have had. It has been a wonderful 100 years—from wilderness to a great state of 10 million people. That has happened nowhere else in this country—possibly in the world. As we look forward to another 100 years of progress, we can do nothing more important than to prepare ourselves to guard the mental health of our people, because no matter what else we have, no matter what the opportunities in our great State may be, no matter what is the condition of our bodies—if our people

do not have good mental health, we cannot have a sound and happy life in California.

I want our institutions to be manned by people of understanding. I want them to be institutions of hope for those who are patients and for those whose loved ones are receiving care. I believe that result can be accomplished. I am sure, also, that there is no group in our State that can do more to bring about this result than you who are in this room today, and I am eternally grateful for the interest you have shown and for the help you have given.

I am pleased that Dr. DuBridge, our Chairman, and some of the sections have suggested that out of this Conference we have a continuing committee which will do something about its findings. I shall be happy to appoint such a committee, and shall ask Dr. DuBridge to select its members.

I have asked the United States Public Health Service to make a complete survey of all our mental hospitals in California, of our procedures, and of our proposed plan for expansion, in order that we may go ahead on a more securely sound basis. The findings of this Conference and of the continuing committee can be of great assistance in making this study.

Again, I wish to thank you all for your splendid participation in this Conference.

SECTION I

PREVENTIVE MENTAL HYGIENE

Chairman: Dr. Wilton L. Halverson
Director, State Department of Public Health

Editorial Writer: Mrs. Helene Lipscomb
Executive Director, Southern California Society for Mental Hygiene

This section defined preventive mental hygiene as meaning the promotion of sound mental health for everyone, particularly the growing child, his parents, and family. This includes all the things we do to and with people which increase their effectiveness and happiness in human relationships.

It was the feeling of the section that this program can well be based upon some simple factors of everyday living:

1. That the home is the place where basic security needs are met and where good mental health begins;
2. That the mental health of the growing individual is related to the understanding of emotional needs and human relationships on the part of all those who live and work with him.

The section strongly emphasized the necessity for the development of a long-term program reaching toward improving mental health.

Recommendations of the Section on Preventive Mental Hygiene are herewith presented, each recommendation being followed by an abstract of the discussion on that specific topic.

Recommendation 1

That action be taken at the local level to establish a representative community council of interested people, both lay and professional, to survey available resources for preventive mental health, to insure the active use of these resources, and to plan for the development of further facilities as identifiable need arises.

Preventive mental hygiene is not an abstruse, mysterious science to be practiced by a few carefully selected, rigidly schooled, and inaccessible practitioners. As suggested in the introductory definition, it includes all the things we do to and with people. It is, therefore, everybody's business. Parents, school teachers, streetcar motormen, physicians, public health officials, grocery clerks —all of us affect and are affected by each other. In the ordinary activities of life we have innumerable opportunities either to help or to harm our fellows.

Preventive mental health begins at home—in the home, for that matter. Its principles should affect our behavior in our daily work, in our schools, in our community organizations. It is for this reason that the section recommends that every one of us should seek out those of our fellows who likewise feel the urgency of this problem and together examine our community and its resources. We should acquaint ourselves with the opportunities for parent

education, with the practices of the schools, with the interests of our physicians, with the programs of our health departments. It is likely that hitherto unsuspected talents and facilities are available in many places, needing only the stimulus of organized interest to begin to function effectively.

When such a community council has achieved a clear picture of the possibilities and practices, it is in a better position to determine the next steps to be taken. At this point, the community should be able to ask for and receive consultation services from the appropriate state agencies, such as the Departments of Education, Mental Hygiene, and Public Health.

The section deliberately voted against designating any particular group or agency to assume leadership; it recognized that in different communities leadership would come from different sources. Many examples were given in the course of discussion illustrating how different groups of individuals or agencies had succeeded in joining forces on certain particular aspects of this problem—in the organization of parent classes, in the provision of special training for teachers, in the closer coordination of the work of several agencies, or in the organization of a child guidance clinic. Each of these activities could be the beginning of a broad community approach to the problem.

This then, is the substance of the first recommendation—that each of us should say, "What is my town doing about preventive mental hygiene—what *should* we do—what *can* we do?"

Recommendation 2

That there is need to give active support to continuing research in this field of mental health. Ignorance, however eagerly applied, will not solve our problems. Funds and impetus, public and private, must be secured for pushing forward the frontiers of knowledge and for evaluating and guiding its application.

Time and again members of the group spoke of the need for more research in the field of preventive mental hygiene. In the first place, although we know a good deal about the kinds of things and situations which affect behavior, from infancy to old age, we do not by any means know everything. The infant has been more minutely studied than the child of school age. As one speaker said, mental hygiene is not an established set of facts and principles, completely contained in a closed system, all written down in a book somewhere. On the contrary, it is a growing, developing, changing field, as witness the change in our attitudes towards the "training" of infants over the past twenty years.

In the second place, we need to know much more about the application of the principles on which there is general agreement. What is the best contribution of the teacher? How much time should kindergarten teachers have for counseling parents? Should the school entrance age be lowered? What is the best contribution of the family pediatrician? Of the public health nurse? What is the most effective relationship between a school guidance system and the community's child guidance clinic? The only way to find out is to study these things, to follow up on community programs and see how they work. Whenever someone establishes a new mental hygiene service, a potential

research program is likewise established; from such objective analyses of the things we do we can learn more about both principles and application.

Recommendation 3

That expanded opportunities for education in the basic principles of growth and development and human relationships be made available to:

a. The educators who train the professional students.

b. The professional workers in the community and community leaders.

c. The parents.

While the previous recommendation suggested that there is much yet to be learned about the principles of mental hygiene and their application, this recommendation is based on the feeling that we are not adequately using that which we have learned already. It is based upon the many statements made at the Conference which pounded away at the idea that all of us—parents, teachers, physicians, nurses—could help our children and our fellow men a great deal more if we were better acquainted with the knowledge already available on growth and human behavior.

How is this to be taught? The section thought of two groups—parents and professional people. For the latter, there are two possibilities—the inclusion of more material in their professional training, and postgraduate training opportunities. The section devoted itself particularly to the training of teachers, physicians, and nurses. These are the ones most apt to come into contact with the growing child and with his family, thus reaching families who cannot be reached in any other way. They occupy, therefore, a position of strategic importance.

The section recommended adequate preparation in the basic principles and practices of mental hygiene as a prerequisite for all teaching credentials. At this point someone pointed out that one could only increase the subject matter in this area either by increasing the length of training or by reducing the time allotted to more traditional or informational types of subjects. Reducing the latter often is resisted by parents and by other groups in the community—this shows again the importance of Recommendation No. 1.

It was generally agreed that teacher-training institutions are devoting more time than before to subjects of mental hygiene significance; nevertheless, it was felt that even more is desirable.

Regardless of how well we train our future teachers, we must still recognize the fact that the majority of teachers now working in the public schools have not been given the kind of training that would help them either to practice or to teach the principles of mental health. One superintendent has attempted to meet this problem by conducting an inservice training course one-half day each week. His teachers participate in a guidance clinic, observing interviews and participating in case discussions. In this they are assisted by professional personnel from a neighboring state hospital. Schools which have good guidance systems, with well-trained counselors, have a resource for inservice training; in some cases, assistance might be secured from the staff of a child guidance clinic. In one East Bay city, educators have participated in regular meetings of representatives of different professional agencies;

at these meetings the agencies have discussed their programs and have presented case material to illustrate the work they are doing and the possibilities of better integration of agency work. Institutes of various kinds in family life problems have been held in many areas, and summer and extension work in this field can help many a teacher to prepare herself better for her everyday job of teaching other human beings.

Physicians have an opportunity to affect our behavior for better or for worse long before teachers do. In fact, obstetricians, by the degree of understanding with which they prepare the expectant mother for her imminent experience of motherhood, can affect the child's mental health before he is born. One speaker felt that the obstetrician was the most important type of physician to train in this respect. The medical profession is showing great interest in this field, as witnessed by the many members of that profession who were present in the section. Not only are the medical schools including more psychological and psychiatric material in the teaching of medical students, but physicians in practice are eager for opportunities to equip themselves more adequately in this field. The American Board of Pediatrics emphasizes growth and development and child behavior in its specialty examinations; and many physicians recognize the chief value of well-baby supervision to be the opportunities for counseling with the mother. Here again there should be expanded opportunities for post-graduate training and for consultation, and for more professional contact with teachers, public health personnel, and welfare agencies. One speaker described the great value of a psychiatric clinic in one general hospital and a psychiatric service in another, in bringing the psychiatrist and the general physician together, thus stimulating the interest of each in the other's problems and offering a real educational experience to the general practitioner. As a faculty member from one of the medical schools said, the further we can go in training medical students to know more about the personal problems of families, and the more we can integrate the training in medical schools with that in other professional schools, the better prepared our future doctors will be.

The nurse often has a closer personal relationship with the family than any other professional worker. A public health nurse, going into the home, spends a good deal of time with families and may represent the family's chief contact with the health department. Here again, the expressed desire was for more training both in nursing schools and in the form of institutes, field training, case discussions, and consultation from other professions.

To sum up, then, the problem is to help those who help the family to develop a better understanding of human behavior, emotional difficulties, family problems, and growth and development. As someone said, it is a matter of how to educate the educator.

Recommendation 4

That greater importance be given to the family:

a. By an attempt on the part of all agencies serving families to include the entire family in its planning to a greater degree so that families may have more time and do more things together.

b. By a broad and extensive program of adult and parent education sponsored jointly by professional and lay community groups to acquaint the public with the basic needs of children and adults and to make them aware of the community resources available or needed to achieve a high standard of family life.

c. By making education for marriage one of our important educational goals. Such education should begin in the kindergarten, teaching children to appreciate the importance of their family, and helping them to understand and solve their problems in becoming increasingly mature boys and girls, young men and women, husbands and wives, fathers and mothers, and grandparents.

This recommendation is actually a summarization of a much longer recommendation which the section on Preventive Mental Hygiene approved by voice vote. Since certain portions were the product of a good deal of discussion, it seems appropriate to reproduce the original recommendation in its entirety at this point:

It is recommended that greater importance be given to the family by:

a. An extensive program of adult and/or parent education—sponsored jointly by professional and lay community groups, with outstanding leadership, carefully planned, and well publicized—in order to reach a large number of people in the community.

b. Making education for marriage one of our important educational goals. Such education would begin in the kindergarten and would include, among other things, an appreciation of the importance of the family to children, adolescents, adults, and to society itself.

c. An understanding and an appreciation of the importance of the role of sex in the life of the individual and of society. This would include among other things an understanding of human reproduction at an early age, the significance of adolescence by adolescents, and assistance in solving the problems of courtship and marriage.

d. Emphasizing the importance of the role of parenthood through education, using appropriate educational materials, by helping the expectant mother and father with their problems and preparing them for parenthood, and by assisting parents with adequate counsel on their own and their children's problems during the life of the family, by such means as:

Parent-child study groups in every neighborhood.

Teachers adequately trained to work with parents, particularly in the kindergarten and early school years, and given adequate time to do so.

Parent-teacher conferences at all grade levels.

Adequate guidance services in every school to assist teachers, parents, and children.

e. Encouraging all agencies serving families to attempt to include the entire family in their planning to a greater degree so that families may have more time and do more things together.

The pattern af family life has changed enormously in the last three generations, even in the last 20 years. As a result of the increasing complexity of our civilization, with its emphasis on specialization and interdependence of people, families now look to others in the social order for many of the things which the family did for itself years ago. Families no longer build their own homes, raise their own food, spin their own cloth, and supply their own entertainment. Furthermore, the decrease in economic and social self-sufficiency of the family unit makes the family more vulnerable to fear and insecurity arising from general social and economic conditions—the fear of war, the fear of losing one's job.

Thus many of the forces which tended to keep families together, by making their members dependent upon the family unit, are no longer operative. Someone remarked that families really don't have to stay together any more unless they want to. Certainly our children are growing up (as we did) with different ideas about the function of a father and a mother. These different ideas arise out of their own experiences and observations. This seems to be a normal change as generation passes into generation, but it is difficult for parents (and children) to accept and understand these changes; and we need more appreciation of this in teaching and in reassuring our parents—and our children.

Nevertheless, father, mother, and the children are still important to each other. During the early development of the child, his whole ability to achieve a happy relationship with others is dependent on the secure relationship between himself and his parents, primarily his mother. When a psychiatrist attempts to work out the emotional problems of a child, he must work with and through the parents also. Physicians, teachers, social workers and nurses, no matter how capable and understanding, cannot replace the parent; the child wants his own parents to be his parents, not somebody else arbitrarily assigned to that function by society.

For every child, then, mental health begins at home. We must help people to learn how to live together in a responsible manner in the family setting.

As the discussion proceeded in the section, many good and useful measures were suggested by which the family could be helped to function more effectively and happily. Many different agencies and individuals have something to offer. This very multiplicity of helping hands, however, was recognized as a potential source of confusion and irritation to the family, as well as a danger in the sense that it might pull individuals away from the family rather than pulling the family together. Thus, after a long and hotly debated discussion, the section voted down a proposal that the compulsory age for school attendance be lowered to two and a half years. The section time and again reiterated that the family should be served as a unit, and that those serving the family should coordinate their efforts—bring more bread in fewer baskets, as it were.

As pointed out in the second portion of this recommendation, one important way of helping parents is through a broad and extensive program of adult and parent education. The section formally called attention to the fact that the California program of adult education provides an already

established agency in most communities of the State whereby educational classes and programs in parent education, mental hygiene, child growth and development, as well as organized counseling programs for groups of adults, can be organized and carried on.

Any community group desiring instruction on child development or family relationships can receive this through the agency of its own schools. Arrangements can be made to bring in any speaker on any subject. This machinery is too little used but it is a tremendous resource. Other types of mass education—meetings, books, movies, and radio—can be arranged through other community agencies. In these activities we have a right to expect parent-teacher groups and mental hygiene societies to assume leadership.

However, group education, valuable as everyone agreed it to be, cannot supply all the needs. Some members of the community will not care to read about mental health, will turn off the mental health radio programs, and will stubbornly fail to put in an appearance at parents' classes. Many parents conscientiously attend these functions and diligently study the works of Gesell and Spock, yet feel confused and uncertain about their own particular problems. They feel guilty and discouraged. What they want, as one delegate said, is *somebody*, not a book or a lecture class, to sit down personally "with me, my husband John, and the rest of the family."

Another problem is that of readiness to learn. The best time to teach people about being parents is when they are parents; most parents are anxious to do a good job with their children; yet the very fact of being a parent makes it more difficult to take the time to attend lectures and classes. On the other hand, they are more apt to be in touch with physicians, both specialists and general practitioners; they may be found attending prenatal clinics and well-baby clinics; they will be visited by public health nurses; they may have placed a child in a nursery school, and eventually they will be the parents of school children.

The members of the section were, then, agreed on the excellent facilities available through our state system of adult education; but they felt that this was not a universal panacea, even when buttressed by all the other media of mass education. They called attention to the opportunities for parent education available to all who come in contact with the family during health and sickness, good times and bad times, and particularly to those responsible for the child's education. These opportunities for service are elaborated in the succeeding recommendations.

Recommendation 5

That the problem of providing adequate housing for the rapidly increasing school-age population be recognized as an essential factor in the development of sound mental health. It is imperative that necessary facilities whereby children can be given an adequate school experience be provided.

The section on Preventive Mental Hygiene recognized that any serious effort to improve the mental health of our people depends for its success upon a comprehensive program of education. This program should embody the

principles of good mental health in its organization and procedures and should provide all individuals, both young and old, with an opportunity to acquire an understanding of mental health principles and procedures as they apply to problems of everyday life. The section therefore adopted the following resolution:

> That this Conference recognize the need for new school buildings commensurate with California's rapidly growing youth population and urge that legislation embodying state participation in this task be enacted. Adequate school facilities and sufficient personnel to provide for the needs of all children are an important part of any preventive mental hygiene program. It is equally important that financial provision be made to staff the public schools with adequately trained, secure, and well-paid personnel. With this in mind, the members of this Conference go on record as supporting legislation which is necessary to make available funds for construction and financing the educational program in our State.

Other resolutions having to do with education will appear in subsequent sections of this report.

The rapid increase in California's population has thrown a tremendous burden upon the schools, the burden of finding both teachers and housing. Crowded classes and double sessions are not conducive to good education—nor to good mental health of either students or teachers. In addition to these difficulties, inflation has whittled the education dollar just as it has other dollars. The schools are engaged in human engineering; the education of 50 years ago was indeed less expensive, but it would no more fit our offspring for the atomic age than the engineering education of 50 years ago could produce rocket ship designers.

Recommendation 6

That the curriculum of the school should be examined carefully from two standpoints:

a. Is the present school curriculum built in such a way as to bring into practice known facts concerning basic principles and techniques of sound mental health practice?

b. Does the present school curriculum provide an opportunity to gain necessary knowledge concerning the basic principles of human motivation and behavior?

The section spent comparatively little time on this point. It recognized, without much debate and with no voices raised in opposition, that the health content of the curriculum is of major importance, and that all children should have ample opportunities in school to become informed on the general subject of human relationships, with particular emphasis on growth and development, on marriage and family life, and on preparation for parenthood. It recognized the need for teachers of special ability and training in this field. It called attention to the fact that many junior high schools have classes in

mental hygiene and that high schools are offering classes in human relationships, sex education, marriage, and family relationships. Some cities are giving high school students a chance to observe and participate in nursery school activities. However, it purposely avoided making any specific recommendations about curriculum; the important thing is to study the curriculum from beginning to end, and then revise it as necessary to give youngsters and adults some understanding of the basic principles of human motivation.

Besides making the recommendations in reference to education for marriage and sex education already quoted in the discussion of Recommendation 4, the section adopted the following resolution:

> That this Conference call for an examination of the present school curriculum by competent professional and lay groups to discover how well it meets the mental health needs of children and adolescents. It is urged that state, county, city, and district departments of education provide leadership in this task and that all conference members assume responsibility for stimulating wide community participation.

Recommendation 7

That every effort should be made to improve both the extent and the quality of guidance services provided through schools for children, youth, and adults. This improvement must come through the increase of adequately trained personnel; the provision of training facilities and programs which can produce such personnel; and a closer cooperation between community groups, parents, and the schools in making such services, when provided, function to the maximum degree of adequacy.

Two years ago a survey conducted by the United States Office of Education revealed that half of the high schools in our State did not have anyone on the staff who could be designated as a student counselor who had full-time responsibility for the school guidance program. If that was true of the high schools, the percentage of elementary schools with organized guidance service was certainly much lower.

This does not mean that in half of the high schools no personal guidance at all was given to the students. As long as there have been schools, there have been teachers whose interest in their pupils' problems has gone beyond the routine duties of the classroom; and as long as there have been schools, there have been children who have not fitted into the prescribed pattern, children felt to present special problems of one kind or another—the aggressive, the withdrawn, the rejected, the unhappy. The truant officer is a familiar figure in our folklore; this represents one attitude. On the other hand, all of us remember certain teachers with affection and respect because of their interest in us as persons, because of their ability to inspire, and because of their service as counselors. All teachers do a certain amount of counseling, some more than others, and some more effectively than others. The purpose of a school guidance program is to make this activity more productive; to bring in people of special training and skills, who will not only themselves do counseling with students and parents, but will also help all the teachers to improve their abilities in working with youngsters. Such a program should take the fullest

advantage of the school health services and of such community services as family service agencies and psychiatric clinics; it should be a part of the whole community program of preventive mental hygiene. The suggestion was made that every school in the State have psychiatrists, social workers, psychologists, and other trained people as part of the school system. This is an ideal which cannot be realized as long as only a few thousand psychiatrists are available to serve many millions of people; but wise planning in the use of all community facilities might make a good service possible sooner than a lot of us ordinarily think. With teachers trained in group work, with teachers able to recognize early behavior problems, with a sound system of school counseling, we could do much more with the same number of psychiatric personnel than we are now doing.

This again calls for more training opportunities, more personnel, more money. The law now permits, for instance, kindergarten teachers to teach kindergarten for half a day and spend the other half day in counseling parents. Such work with parents, at a time when the child is starting his long journey through the school system, can be of great value. However, few schools are doing this. The pressures of an over-supply of children, an abysmal lack of housing, and an under-supply of properly qualified teachers, is forcing them to teach double sessions, with no time for counseling.

Finally, as one participant pointed out, the students are not the only ones who benefit from a good guidance service. Teachers themselves are not educational automatons; they too have personal and family problems; they too get wound up emotionally; and they can be helped by a good guidance program.

It was with these things in mind, therefore, that the section passed the following resolution:

> That, in order to provide more effective mental hygiene services to students and parents, this Conference go on record as favoring the extension of school guidance services. This will require further study and definition of the roles of various specialists such as counselors, psychologists, school social workers, and others, and a clearer understanding of the guidance responsibilities of teachers and all other school staff members. It will also require the establishment of new positions in many schools and the partial revision of existing certification requirements.

Recommendation 8

That the provision of an inclusive generalized program for community health, guided in all of its aspects by the principles of mental health, be a responsibility of every physician and every health department. This type of community program necessitates the integration of the mental hygiene concept into all agencies and individuals dealing with family problems, which means the focusing of the service on the family as a unit.

The section devoted a good deal of time and consideration to the responsibilities of the school system in teaching the principles of mental health to parents and children and in helping them with their problems. However, it recognized the unique opportunities for giving this service which are available to another set of workers—those in the health field. The physician in

practice deals many times a day with persons who are in very special need of help, and who look to him for assistance. Everyone is sick at some time; almost everyone consults a physician for some problem or other during the year, and in the majority of these problems emotional factors are not only of great importance but many constitute the whole problem. Practically all babies in this State are delivered by physicians who therefore have a great opportunity to help the mother. The physician is also the one person most likely to be in contact with young parents, giving health supervision to their small children. Patients with chronic illness are especially dependent upon the physician; and he is in contact with parents whose children are not served by the schools because of such confining illnesses as rheumatic fever.

The physician works in partnership with a host of other workers and agencies—nurses, social workers, hospitals, and health departments. The school programs are concentrated in a certain age spectrum; the health workers, whether practicing physician or public health department, serve all the people. Public health workers are learning that mental health is a part of every phase of public health just as it is a part of every phase of medicine; it cannot be compartmented off as a separate administrative unit. The sanitarian who deals with a recalcitrant food handler must understand the personal and emotional factors responsible for the latter's defiant attitude, just as the health officer must employ sound mental health principles in working with the members of his own staff. Health departments are finding that an interest in the attitudes and personal problems of patients with venereal disease is more effective in producing regular attendance at clinic than reliance upon techniques of fear and force.

In recognition of these facts, therefore, the section makes the following recommendation for the strengthening of the mental health aspects of the community health program:

> The provision of an inclusive generalized program for community health, guided in all of its aspects by the principles of mental health, is the responsibility of every physician and every health department. This type of community program necessitates the integration of the mental hygiene concept into all agencies and individuals dealing with family problems. This means the focusing of service on the family as a unit.
>
> Such a program necessitates provision in the community, by the health department, other local agency, or from the state level, of the following services:
>
> a. Psychiatric consultation service.
> b. The psychiatrically trained social worker and public health nurse.
> c. Development of inservice training facilities for staff members, including public health nurses, physicians, sanitarians, clerical staff, volunteers, and others.
>
> The program can be integrated into and around the existing community public health program, by community discussion and planning groups, consisting of all agencies working with family problems; by the application of mental hygiene principles to prenatal and child health

conference procedures and practices; and by the application of these principles to special programs such as venereal disease, tuberculosis, and chronic diseases; by more generalization of the public health programs to consider the family as the unit of service; and by the closer integration of the public health program of the community with the schools, social agencies, legal agencies, and private practitioners.

Recommendation 9

That there be an enlargement by the State Department of Mental Hygiene of consultative and advisory services in mental health to local communities, as well as an expansion of existing services provided by the State Department of Public Health and the State Department of Education.

This recommendation is, in a sense, a corollary of Recommendation 1. The section recognized the importance of local interest and local planning in the development of community mental hygiene programs; but it also emphasized repeatedly the need for leadership and consultation from state agencies. No one wanted to see a program "started at the top" or "imposed" on communities; but the delegates also were quite certain that as communities began to wrestle with their problems of organization and facilities, they would realize their need for some help from outside and would ask for it. Some would feel this need sooner than others, depending upon the resources available to them locally. One participant spoke of the need of small communities, with populations of 3,000 or less, unable to command the services of a well-trained teacher, let alone a social worker or a psychiatrist. Another spoke of the great interest shown by people in some of the rural areas in this mental hygiene problem, and of the personnel problems with which they are faced. Another used, as an example, the work of the Youth Authority in giving active leadership to local areas in the field of community education and organization.

Services from the state departments could be of different kinds. The Department of Education is already helping local school districts with such projects as curriculum, adult education, kindergarten, and guidance services, all of which have great mental health implications. The direction of the child care center programs, which was much discussed, offers many opportunities for constructive health activities. Training programs for teachers, including institutes and workshops, are a means of helping them to achieve a better understanding of the importance of emotional growth and personality problems.

The Department of Public Health is carrying on consultation work in the field of preventive mental health which attempts to weave these concepts into all the various activities of local health departments. The mental health consultant helps physicians, nurses, clerks, sanitarians, and other health workers to do more effective work in their respective fields by developing more understanding of their relationships with people, by utilizing their own talents more effectively, and by taking more advantage of other resources in the community. Since there are not enough specialized people in the

State to permit the establishment of a mental hygiene clinic in every community, the Department of Health is interested in helping each community to recognize and to make use of the potentialities for good preventive mental health work which already exist within it.

The section felt that the Department of Mental Hygiene should do much more in the field of preventive mental health than it has so far done. Various speakers called attention to the need for an expansion of the mental hygiene clinic program, for the development of traveling clinics, for the expansion of a field staff to provide more case consultation services by psychiatrically trained workers in the rural areas.

None of these services is new. The section was simply asking for an expansion of services for which the demand already exceeds the supply; and as more communities begin to tackle their problems, the demand will become ever greater.

Recommendation 10

That communities recognize the importance of recreation to mental health, and that both public recreation and private group work programs for all age levels be encouraged and supported.

In the opening session of the Conference, Dr. Overholser referred to the fact that psychiatrists have discovered the values of recreation. In the course of the section meeting another psychiatrist, Dr. William G. Menninger, was quoted at length on this subject: he was, in a sense, a consultant *in absentia.* According to Dr. Menninger, "An effective community recreation program is just as important to mental health as sanitation is to physical health." It was pointed out that we have known for years the value of vigorous big muscle activity in working off feelings of aggression; the significance of group experience in developing feelings of security and acceptance of social responsibility; and the indispensable place of the arts and crafts in fulfilling the creative urge. Recreation is a morale builder, and should not be considered either a luxury, a childish waste of time, or a sin. "Good mental health," Dr. Menninger was reported to have said, "is directly related to the capacity and willingness of an individual to play. Regardless of his objections, resistances, or past practice, any individual will make a wise investment for himself if he does plan time for his play and take it seriously." However, the most constructive and beneficial play is neither an accidental ability nor an inherited trait; and for maximum benefits one requires not only encouragement but almost always some instruction, and therefore some type of community organization.

Recommendation 11

That, because poverty and ignorance are so frequently in the casual pattern of personality problems, the best defense in mental hygiene is a strong offensive for a better life for all people. This would mean:

a. Better schools.

b. Better housing, especially the clearing out of all city and rural slum areas.

c. Security of employment.
d. Certainty of health services for every family.
e. Increased recreational areas and opportunities.

Recommendation 12

That there be a small continuing statewide committee to formulate and promote plans for future actions.

There were approximately thirty-one resolutions submitted which the group did not have time to consider. The section voted in favor of having these resolutions printed as a part of this summary; but considerations of space make this impossible. The resolutions dealt with the same areas which have already been covered in this summary; and, in the preparation of the summary, the material in the resolutions was drawn upon as freely as the actual transcript of the proceedings. In other words, a delegate who failed to find an opportunity to speak (there were approximately 250 people in the room), but who submitted a written statement, will find that his ideas were given equal consideration with those of the speakers. Many of the resolutions were obviously carefully thought out and painstakingly prepared. They indicated clearly that the participation of the delegates was not limited to the actual hours in the meeting; they demonstrated that a good many small and informal discussion groups must have carried on the work of the section into the small hours of the night which separated the two days of the meeting. It was this spirit of profound interest and enthusiasm, this almost overwhelming feeling of urgency in regard to preventive mental health, which was so characteristic of the meetings of this section.

SECTION II

COMMUNITY TREATMENT AND WELFARE SERVICES

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"Mental health services include all those provisions which a society makes for the prevention and alleviation of mental disorders and of the personal and social disturbances that those disorders bring in their train."

This quotation from the International Congress on Mental Health (1948), was the keynote of the Editorial Writer's preliminary statement to this section.

In recent years, provision for mental health services has progressed along three main lines: (1) institutional care, (2) facilities for care and treatment in the community, and (3) increasing emphasis on prevention. With respect to community facilities, there are two major areas of service, one concerned with early treatment and the other with convalescent care.

Community facilities for early treatment may include psychiatric outpatient departments of general hospitals, psychiatric clinics, family and children's agencies, school guidance programs, probation departments, vocational counseling, industrial counseling, rehabilitation centers, marriage counseling, and parent education. With modern methods of treatment, many mentally ill persons can be cared for in outpatient centers or in general hospitals and need never be sent to a state hospital. Furthermore, extension of these facilities for care of the mentally ill would make it possible for the local community to obtain the services of a psychiatrist who would otherwise hesitate to go into practice away from a metropolitan center. Concomitant gains would be a more rapid disappearance of the stigma attached to a mental illness which necessitates removal to a state hospital, a more careful study and correction of the factors of stress in the local community and the home which lead to mental breakdown, more emphasis on the need to correct generally harmful influences in the community, and the ability to obtain competent personnel to establish early treatment centers and to give consultative, educational service to all agencies directly or indirectly concerned with the problem of mental health. Experience has shown that sound social welfare work in the community is a prerequisite to the full use of psychiatric clinics and hospitals. All such activities under competently trained leadership can be regarded as early treatment and should be encouraged in planning well-rounded mental hygiene programs at the community level.

These community resources, integrated into an individual treatment plan, may also be useful in promoting the readjustment of the patient who leaves a state hospital or a state home. Many patients need help in making the transition from mental hospital life to community and family life a constructive process for all concerned. Frequently much work needs to be done to prepare patients for return to the community. The patient may become acutely anxious about going home. Also, the family and community need preparation to receive the patient. In some instances the patient, although ready to leave the hospital, cannot go home because the family and/or the community is not ready and willing to receive him. To return him to home and community under such conditions is to permit re-creation of the same destructive forces which brought about his breakdown. Adequate service to returning patients and their families usually requires that the psychiatric social worker do her job in the community while maintaining a very close working relationship with the hospital staff. Psychiatric social workers may also be responsible for providing family care homes for patients who are unable to return to their own family or community. In larger communities, convalescent care can be provided through outpatient centers, such as clinics or outpatient psychiatric departments of hospitals. In general, it may be said that community psychiatrists are more familiar with the needs of the patient in the community and are also better equipped professionally to give psychotherapeutic care than the state hospital staff. Also, these centers are usually staffed with psychiatric social workers and the other professional personnel needed in a well-rounded treatment program.

In the discussion it became evident that each community feels the impact of its own mental health problems and recognizes its failure to solve them. An adequate program of mental hygiene must be concerned with both treatment and prevention—with helping people to remain out of hospitals and with the promotion of satisfactory living. When mental hygiene was oriented toward custody of psychiatric patients the gaps were in terms of institutional facilities. But now in the light of increased knowledge about mental health, we believe that hospitalization can be prevented or shortened if an adequate community treatment program is available to all who need it.

No communities can claim to have adequate treatment programs. There is also need for a better understanding and use of available facilities. Some of the groups dealing with problems of mental health are unknown to others. In order to make the best use of psychiatric facilities and to avoid loss of time in getting people to the proper agencies for treatment, an educational program regarding available resources is needed. In some areas this might be accomplished by mental health councils; in metropolitan areas it might be accomplished through councils of social agencies. It is imperative that people in the community use such groups to pool their thinking and experience and to capitalize upon the interest in mental health which they represent. The approach could be twofold, acquainting people with facilities and coordination of existing resources.

Since there are state, city, and county public and private organizations all interested in mental health, the need for a more integrated program is

evident. Such integration would point the way to deciding what new agencies are needed and what existing agencies should be expanded in order to reach out to more people who need their services. Some factors which now limit psychiatric treatment in the local community are the inability of county hospitals to provide treatment for acute cases of mental illness for a period up to three months, the negative attitude of insurance companies toward allowances for treatment of mental illness, and the lack of psychiatric facilities in private hospitals. There is interest in expanding private facilities but the funds to underwrite expansion are lacking. The director of the psychiatric department of one county hospital estimated that commitments to state hospitals from his county could be cut in half if his hospital were permitted to provide intensive treatment for a period up to three months. The experience in veterans' service centers has shown that outpatient treatment obviates the necessity for many state hospital commitments.

Public funds and voluntary contributions from city, county, and state should be coordinated in order to provide maximum facilities for care and treatment. Public and private general hospitals should be given financial assistance to establish clinic facilities for mental health. More emphasis should be put on seeing that hospitals built under the Hospital Construction Act do have these facilities.

Under the National Mental Health Act federal funds are provided for training stipends and grants-in-aid to psychiatrists, psychiatric social workers, psychiatric nurses, and psychologists. The amount of money appropriated is only a fraction of the actual need in the various states. However, there is also a need for wider awareness that the funds do exist and can be used.

Discussion was also directed toward the special mental health problems encountered in rural areas. There is very little available for children in rural communities. In schools children are seen who need help with their emotional problems, but this help is difficult to secure and sometimes totally lacking. Yet if treatment begins early there is a better chance for normal adjustment. Lack of money for financing treatment facilities handicaps many communities. Even metropolitan areas have expressed concern over the shrinking dollar. In many counties, child welfare units which have been requested cannot be financed because of budget limitations. More complete welfare services should be provided within all of our local public agencies.

It was suggested that greater imagination and inventiveness are needed in planning treatment and welfare services, and that planning should always be related to the particular facilities in the community. A thorough understanding of the specific local problems makes it possible to meet them with a flexible approach and an original method.

General hospitals and clinics necessarily serve a limited territory, although they do have the advantage of treating the person in the community where he lives. A traveling clinic might bring psychiatric services to a local community but when such a clinic serves a wide area its influence on local mental health problems is slight, unless there is a local social worker able to carry on the work in the intervals between visits of the other clinic personnel.

Unless the traveling clinic has a local base to guarantee continuity of its services, the results of treatment are negligible.

In Contra Costa County it was found that because of long waiting lists people could not get service from clinics in metropolitan districts. Nor were there adequate funds to establish a guidance clinic. However, with a grant from public sources a plan was developed to use a psychiatrist as part-time consultant to four agencies dealing with children. Once a month the psychiatrist was available for consultation with the staffs of each agency. The staff members are of varied training and competency, but for the first time they are all being helped to handle problems that they could not handle alone. In rural counties the psychiatric social workers of the Department of Mental Hygiene are being used to a limited extent as consultants on emotional problems. In many areas schools, county welfare offices, and public health units need help in dealing with the many emotional and mental problems that come to their attention. Due to the lack of specialized casework services these public agencies are often called upon to give help to emotionally ill people who have no other community resource to which they can turn. Studies to determine the kinds of problems that could best be handled by each organization might lead to more efficient use of existing services. Furthermore, it could then be determined which public agency services might best be expanded to meet the needs within particular communities.

The need for coordination and more effective use of existing community facilities might be met by provision of "a crossroads place," possibly a social service unit, where people could bring their problems and be directed to the proper resource for help. In metropolitan areas there are well developed social agencies to peform this function, but in the rural counties the public agencies might serve as the crossroads for handling these problems of family living and mental health.

There should be consolidation of existing community services and better coordination of the services offered by public agencies in the counties as well as at the state level. This is essential if the staffs of the State Department of Mental Hygiene and the county social welfare agencies are to be used effectively.

The case of a patient recently placed on leave from one of the state hospitals served to dramatize the need for coordination of services on the local level. Soon after the woman went home her husband deserted her in a labor camp. She had a 14-month-old child and was completely without resources. She applied to the welfare department for indigent aid and received it. She went to the district attorney to file a complaint against her husband for desertion. She then had to go to the child welfare clinic about her child and to the local probation department. She was running from one place to the other; yet she was still a rather sick person and it was very disturbing to have to go from person to person for help. Upon learning of the situation, the worker from the Department of Mental Hygiene immediately met with the local agencies involved and together they worked out a cooperative plan of treatment for this patient.

A basically therapeutic approach in meeting the mental health needs of the State is needed. All existing treatment and community welfare facilities should be reviewed in terms of their present contributions to mental health and changes which might be made to provide more adequate services. We already know that our facilities are inadequate. We know that conventional clinics cannot provide individual treatment for all who need it. The cost is too great and the personnel is not available. We must use other approaches as well.

It is not necessary to blueprint a single therapeutic program that every locality should follow. Whenever possible local interest and local needs should influence and mould the program. Some responsible local group is also needed to reach an understanding of local mental health problems, to consider methods of dealing with these problems, to focus the program, and to carry the responsibility for developing and coordinating services.

The provision of reasonably adequate facilities to take care of mental breakdown in children and adults could make a substantial reduction in the number of people committed to institutions. Facilities designed to enable convalescent patients to readjust in their local communities are not enough; understanding, sustaining people are also needed to assist patients to use existing community facilities to make an optimum social adjustment. Local communities should be encouraged to develop their own psychiatric treatment resources. However, where this is not possible it seems essential for the State to provide both financial support and guidance.

The financing of a mental health program must eventually come from the people themselves. How much money is provided depends upon how many taxpayers are deeply concerned about the situation. Therefore, it is extremely important for the people in each local community to know what its mental health problems are and how they are being met.

In order to achieve a therapeutic program throughout the State, it is necessary to present it clearly to the taxpayers and to the Legislature. Their support is essential to bring any worthwhile program to consummation. Hence the recommendations of this Conference should be taken back to the local communities and the people should be urged to get behind them.

This section makes the following recommendations:

1. That there should be a major orientation of the program of the State Department of Mental Hygiene toward the development and expansion of local community treatment and welfare services, at the same time that we are improving facilities for state hospital care and treatment.
2. That a Division of Community Services be established in the Department of Mental Hygiene.
   a. Further, that the director of this division be appointed chairman of a permanent committee composed of representatives from all state agencies having an interest in mental health, which committee should be responsible, through consultation, for the coordination of all state mental health activities.

b. Further, that this division be charged with the coordination through consultation of all mental health activities on the local level, utilizing local facilities, both public and private, when advisable.
c. Further, that funds be appropriated to implement this division.
d. Further, that competent professional personnel be secured in all classifications involved, and that appropriations for salaries be adequate to attract such personnel.
e. Further, that in the development of services, provision be made for funds to be spent on research for new and better methods of treatment, and for training of personnel at all levels.

The goal of treatment is a return to community living, with the fullest utilization of all resources necessary for the personal, social, and vocational rehabilitation of the patient. To that end there should be greater emphasis on the present social work program with convalescent patients in the community and in family care. Schools, courts, public welfare departments, and vocational services all have personnel who need an understanding of mental hygiene problems. Narrow interpretation of policies can interfere with patients' ability to remain out of the hospital. Particularly in rural areas should the psychiatric social worker collaborate with personnel in community agencies, inasmuch as the services of these agencies are essential to promote the well-being of convalescent patients. Therefore, it is recommended:

3. That the staff of the Bureau of Social Work be augmented so as to give service not only to patients on leave of absence from state hospitals but also to other persons needing psychiatric social service, in areas where there is no other such service, and that the Bureau psychiatric social workers be available for consultation to other agencies in need of psychiatric orientation.

An expanded clinic program would make it possible to provide early treatment for emotionally disturbed people before their illness becomes more severe and they require hospital care. If traveling clinics are developed so as to reach into counties that lack such psychiatric resources, these could be built around the local county-assigned psychiatric social worker who would be in a key position to know the community, to make use of other community resources, to give interim service as needed, and to arrange for psychiatric consultation where advisable.

Inasmuch as recent legislation for the education of the mentally retarded in our public schools has given legal status and impetus to the organization of school guidance clinics, it is recommended:

4. That the Conference favor the extension of child guidance clinics and mental hygiene services in connection with city and county school departments of the State and that public funds be allocated to support this type of clinical service and treatment.

We must have a diversified approach to these problems and not only use orthodox psychotherapeutic techniques. It is essential, therefore, that communities develop more adequate family and children's services, vocational and educational programs, and health services. Existing community agencies are faced with budgets that limit their expansion, but if enough people are concerned about these problems further resources might be developed. Therefore, we recommend:

5. That due emphasis be given to the importance of various local welfare services which are not the responsibility of the State Department of Mental Hygiene. These community services include public assistance, medical care, employment, housing, family counseling, and rehabilitation services, all of which are necessary for the well-being of the community and more specifically for the individual mental health of all persons in the community. This recommendation is made partly in recognition of the fact that psychiatric service is not a substitute for adequate community welfare services.
6. Finally, we recommend that a mental health continuing committee be set up to implement the recommendations of the Conference.

SECTION III

INSTITUTIONAL TREATMENT AND CARE OF THE MENTALLY ILL

Chairman: Dr. Karl M. Bowman
Professor of Psychiatry, University of California
Medical Superintendent, The Langley Porter Clinic

Editorial Writer: Dr. Judd Marmor
Staff Psychiatrist and Consultant, Mental Hygiene Clinic
Veterans Administration

This section was assigned to discuss institutional treatment and care of the mentally ill in California. In his preliminary statement the Editorial Writer presented the problem and proposed remedies.

Statement of the Problem

The subject of the institutional treatment and care of the mentally ill in California encompasses not one but many problems.

Our present institutions are seriously overcrowded to the point of being critical. This overcrowding has reached approximately 135 percent of capacity in our Southern California institutions, and approximately 110 percent of capacity in our Northern California institutions. For the State as a whole it is now almost 120 percent of capacity.

There is a serious shortage of personnel in all categories—psychiatrists, social workers, psychologists, nurses, occupational therapists, physiotherapists, and attendants. According to the standards of the American Psychiatric Association, the ratio of psychiatrists to patients under the best of circumstances should not be less than 1 to 30, and under the worst of circumstances, at least 1 to 200. In our institutions the present ratio is roughly 1 to 250, an understaffing of anywhere from 25 percent to 700 percent. For all types of nursing personnel the minimum ratio should be 1 to 4 patients on a 40-hour basis. In the state mental hospitals the present ratio is 1 to 7; the goal set by the Department of Mental Hygiene for June 30, 1950, is 1 to 6. To reach even the Department's standards would require approximately 1,200 additional nursing personnel. The ratio of graduate nurses to patients in the California hospitals is 1 to 300. It should be not less than 1 to 40, and for some types of patients it should be 1 to 4. According to American Psychiatric Association standards we are understaffed 300 percent in social worker personnel. Similar inadequacies obtain in every professional category.

Treatment facilities are pitifully unequal to the needs of the hospital population, first because of the insufficient number of treatment personnel, and second because of an actual shortage of facilities for electric and insulin

shock, psychosurgery, physiotherapy, and occupational therapy. This inevitably has a serious effect on the duration of hospital stay and on the rate of discharge, with a consequent aggravation of the overcrowding problem.

Factors Underlying These Problems

The rapid and remarkable increase in the population of the State. The two major urban areas of California, from which more than 55 percent of all new mental hospital admissions come each year, have increased in population by more than 45 percent since 1940.

The increase in mental hospital population. Since 1940 the resident population in mental institutions has increased from approximately 23,000 patients to approximately 30,000, with the present annual increase estimated at about 2,100 patients per year.

Relatively low wage scales for state hospital employees. In view of the marked increase in living costs over the past 10 years, this is an obvious factor in the difficulty of attracting greater numbers of qualified personnel.

Inadequate numbers of authorized personnel in most categories. This is a mistaken notion of legislative economy, since failure to provide adequate medical care for our mentally ill increases the length of hospital stay and so inevitably leads to greater final costs.

Preservation of the traditional type of isolated custodial institutions, located far from large centers of population, has proved inadequate to meet the requirements of modern psychiatric therapy as it has evolved in the past few decades. This is a factor of major importance which requires further elaboration.

The proponents of this traditional pattern of mental institutions advance the following arguments in its favor:

1. Land is less expensive in rural areas.
2. More land is available, thus allowing for development of farm projects, which not only furnish occupational therapy but also make the institution partially self-supporting.
3. Removal of mental institutions to less accessible areas avoids the possibility of their becoming foci of public anxiety or irritation.

Against these arguments the opponents of the traditional system advance the following points:

1. The cost of constructing housing accommodations for all hospital personnel, much of which could be obviated by building hospitals in urban centers, substantially offsets the saving on land costs.
2. Large hospital ground areas are neither necessary nor advisable under a modern program of psychiatric therapy, which should be built around much smaller treatment units with active outpatient services.
3. In actual practice, urban treatment units have not caused any negative public reactions. In New York City, for example, the Payne Whitney Clinic and the New York State Psychiatric Institute are both located in congested urban areas and have caused no untoward community reactions. In our own State, The Langley Porter Clinic

in San Francisco is another example in point. Moreover, it is argued, such urbanization of mental hospitals may actually serve a constructive mental hygiene purpose in helping to remove the present "leprosarium" status of mental hospitals and in educating the public towards a therapeutic rather than a custodial concept of mental hospitalization.

In addition to these negative arguments, however, the advocates of community treatment centers present the following positive considerations:

1. Such centers would help to solve the problem of obtaining adequate personnel. Professional workers in all categories would be more willing to work in urban hospitals where they would be closer to friends, relatives, and professional colleagues, as well as to teaching and research facilities. More and more psychiatrists, for example, are now seeking psychoanalytic training and are, therefore, extremely reluctant to isolate themselves in hospitals where such training and stimuli are unavailable. Attendants too would be more readily obtainable in populous areas where the attractions and diversions of city life are more accessible.
2. Such centers would permit the association and collaboration of many part-time psychiatrists and psychiatric consultants, who would add considerably to the vitality and scientific ferment of professional life in the mental hospital.
3. Such centers would make possible an active association with medical schools and thus become vital factors in the mental hygiene training and education of the community. The staff of the mental hospital, instead of being isolated, would be able to participate actively not only in the teaching of medical students, social workers, and psychologists, but also in the education of the community at large, and in more active research to the mutual benefit of the psychiatrist and the community.
4. Such centers would make possible the establishment of outpatient clinics as an integral part of the treatment program. Modern psychiatric treatment of the functional psychoses often involves relatively brief periods of hospitalization with prolonged follow-up periods of outpatient care. Moreover, many patients who are not institutionalized might well receive ambulatory shock treatment on an outpatient basis.
5. Such centers would make it easier to contact relatives in order to obtain histories and to mobilize their support and understanding in the after-care of the mentally ill. This is particularly important in childhood mental illnesses, where work with the parents is an integral part of the therapeutic task.

The Proposed Remedies

The current construction program of our State is oriented around expansion of the present traditional mental hospital system. That our State Department of Mental Hygiene is aware of the deficiencies of this approach has

been indicated by statements of various Department officials pointing to the need for a revision of this program. One of these officials, Mr. Carl E. Applegate, stated in November, 1948, that if present population trends continue and all new beds which are now authorized are completed before June 30, 1950, our average overcrowding in the mental hospitals on that date will be 30.8 percent.

According to Mr. Applegate this means that when the current program is completed a year and a half from now the overcrowding in our state mental hospitals will have increased from 16 percent to almost 31 percent. In short, we will be almost twice as badly off as we are today.

This is a most serious and untenable situation, one which we cannot face with equanimity. There seem to be two major approaches to this institutional dilemma. We are now 5,000 beds short in our mental hospital system and in a year and a half we will be almost 8,000 beds short, at the present rate of increase in hospital population. This means that if we wish to cope with the problem in the traditional manner we must immediately begin the construction of the equivalent of three new hospital units of 2,500 beds each and staff them with personnel, and thereafter build and staff the equivalent of a new 2,100-bed hospital every year to keep up with the anticipated annual increase in hospital population.

The alternative approach would call for a courageous scrapping of traditional concepts and a gearing of our institutional program to the concept of therapy rather than that of custody. We would have to bend every effort towards devising a hospital system geared to the highest possible discharge rate and to a program of modern outpatient care. This would seem to point in the direction of immediately building active treatment hospitals located in the two main urban centers, Los Angeles and the San Francisco Bay area, from which 55 percent of all of our new admissions come each year. If the huge flow of new patients from these areas could be locally cared for by such urban centers, our present rural institutions could adequately handle the remaining 45 percent of admissions from the rural areas without any major expansion of their facilities for some years to come.

As a means of further implementing this program on the broadest possible scale, consideration might also be given to the possibility of subsidizing beds for treatment of acute psychiatric problems in general and county hospitals throughout the entire State.

Following Dr. Marmor's preliminary statement Dr. Bowman introduced into the record an editorial from the San Francisco News, February 21, 1949, which made the following proposals, in brief:

1. Place the State Department of Mental Hygiene under control of a strong director.
2. Provide existing mental hospitals with adequate appropriations for hiring needed personnel.
3. Take control of medical policies out of the hands of the State Department of Finance and the Legislative Auditor.
4. Expedite the present hospital building program, but focus on curing and releasing larger numbers of patients.

5. Work out methods for treating patients in county and general hospitals nearer to their homes..
6. Extend and improve the services of the State's mental hygiene clinics.
7. Carry on an intensive program of public education about prevention of mental illness.
8. Revise present laws so as to remove the stigma of "criminal commitment" for people committed to mental hospitals by court order.
9. Make the state hospital service more attractive through financial and other inducements.
10. Provide "at home" care and treatment for more patients.

A representative of the California Citizens' Committee for Mental Hygiene introduced recommendations for:

1. Immediate construction of three acute treatment centers in California —one in Alameda County, and two in metropolitan Los Angeles.
2. Utilization of county hospital psychiatric units as acute treatment centers.
3. Expansion of general hospital psychiatric facilities.
4. Establishment of a personnel recruitment and training program.
5. The establishment of a lay committee to act as advisers.
6. Reconstitution of existing rural custodial institutions to serve four basic custodial needs:
   a. Detention and treatment of the criminally insane.
   b. Custody of the mentally defective.
   c. Care of the senile.
   d. Treatment and custody of chronic alcoholics.

A representative of the Southern California Society for Mental Hygiene introduced the recommendations of that society for:

1. Immediate establishment of an urban treatment center in Los Angeles County.
2. Appropriations for complete study of mental health problems in California.
3. Establishment of a Mental Health Commission to study and coordinate mental health problems of the State.
4. Establishment of a technical advisory committee to the State Department of Mental Hygiene.
5. Development of outpatient clinics in connection with existing mental hospitals.
6. Expansion of state mental hygiene clinics.
7. Appropriation of special funds for the expansion of training in psychiatry, psychiatric social work, psychology, nursing, etc.
8. Provision of short-term treatment facilities in the Los Angeles County General Hospital.

Most of the ensuing discussion concerned the problems of treatment and care for all patients in our state hospitals, but special recognition was given to the needs of two classes of patients, children and the aged.

The group recognized the urgent need for more adequate hospital and outpatient clinic facilities for the treatment of mentally ill children. The value of treating the child close to the family and the home was pointed out. There was a difference of opinion as to whether there should be separate institutions for the treatment of children, but complete agreement as to the vital importance of segregating children from adult patients.

Three specific suggestions were made in relation to treatment and care for the aged mentally ill: greater assumption of responsibility by the counties, wider use of family care homes under the supervision of the State Department of Mental Hygiene, and the possibility of partial state subsidy for beds in private facilities.

In considering the general problems of institutional treatment and care, many discussants stressed the vital necessity for immediate expansion of our existing state hospitals and construction of new diagnostic and treatment facilities. Increased appropriations, immediate release of already earmarked building funds, and prompt action by the Bureau of Architecture are essential to the building program of the Department of Mental Hygiene.

However, our concern for the building program must not overshadow the problem of securing adequate personnel to man present and projected facilities for the treatment and care of the mentally ill.

The section saw the vital necessity of informing the Legislature and the people of California as to the needs of our state hospital program. Because of budget limitations our critically overcrowded hospitals are also seriously understaffed. It is significant that Camarillo State Hospital has only 15 doctors for 5,000 patients, while Brentwood Veterans Administration has 80 doctors for 1,900 patients. There are serious personnel shortages in almost every state hospital job classification.

In order to help the existing state hospitals to care for their increasing loads during the interval of several years before new construction can be completed, the section agreed that personnel levels should be raised at least to the minimum standards of the American Psychiatric Association. A number of steps can be taken to attract and hold more and better personnel for the state hospital service: an emphasis in intraining and research, clearer definition of function in each job classification, and raised salaries for all classes of personnel. At the present time guards in California state prisons are far better paid than attendants in California state mental hospitals. The minimum wage for prison guards is $235 a month. The maximum wage for attendants is $220 a month.

Another approach to the problem of inadequate state hospital personnel is the "teamwork" concept, which was advanced in a recent Menninger report as a means of providing adequate mental hospital treatment despite the acute shortage of psychiatrists now and for many years to come. The psychiatrist, psychiatric nurse, hospital attendant, and psychiatric social worker, functioning as a team, may accomplish as much as four or five psychiatrists. Often the teamwork approach produces results which cannot be achieved by work on an individual basis. Some of the more advanced state hospital systems, such as that in New York State, have developed this concept through the

establishment of directors for each type of personnel involved, with assurance of uniform policies through coordination on the state level by the centralized authority of the Department of Mental Hygiene and other responsible agencies of the executive branch of the government.

Many participants stressed the importance of using general hospitals for treatment purposes, as a sound long-term program and an immediate means of reducing pressure on the state hospital system. The State would need to participate in the plan by subsidizing beds for psychiatric treatment. This plan has sound medical precedent, would benefit the patient, and would assist in the training of doctors and nurses. One discussant felt that the Welfare and Institutions Code might be interpreted to allow such treatment, and it was pointed out that the State Department of Mental Hygiene has introduced in the present Legislature a bill (Assembly Bill 1706) which would specifically permit county psychopathic hospitals to treat patients for periods up to 90 days.

There was wide agreement on the urgent need for the establishment of diagnostic and acute treatment centers in metropolitan areas. Such centers should admit patients directly from the community according to their need for hospital care. Screening would be done by admitting physicians just as in general hospitals, and necessary court hearings could be held in the treatment centers. Bed capacity of the centers should be determined by the needs of each community.

An acute treatment center can turn over its entire population four times a year, thus treating four times its bed capacity each year. Hence the establishment of such centers may be considered an economical use of limited building funds.

Location of centers in a metropolitan area would attract better personnel and solve many housing and transportation difficulties. Another important factor is proximity to extended community facilities for recreation, vocational rehabilitation, and specialized medical care. Although there may be some initial community resistance to urban treatment centers, this can be overcome through interpretation and education, and the community can then gain a real understanding of the value of adequate mental health care.

It is evident that affiliation of such centers with medical schools has many values for treatment, research, consultation, and training. However, it was agreed that the Department of Mental Hygiene would retain administrative control, would determine admission and treatment policies, and would make staff appointments.

In the light of the foregoing discussion, this section presents the following findings:

The members of the section wish to convey to Governor Earl Warren their appreciation for the opportunity afforded them to help our State in the crisis in which it finds itself with respect to the problem of the care of the mentally ill.

The members of our section also wish to express their recognition of the devoted services of our loyal employees of all classifications in the Department of Mental Hygiene, who have carried on their work faithfully under the most trying of circumstances.

Our section discussion has unanimously confirmed the fact that the state mental hospitals are overcrowded and understaffed to the point where our mental patients are receiving dangerously inadequate medical care. Drastic changes in facilities and treatment services are imperative at this time to prevent further deterioration.

Our section makes the following recommendations, the first two of which are considered to be urgent and inseparable in the solution of the present crisis:

1. We unanimously recommend an immediate expansion of our present hospital capacities, as well as revitalization of their present facilities, so as to increase their treatment potentialities to the maximum. The immediate release of funds already earmarked for such construction is an imperative necessity.
2. Simultaneously, however, there should be construction of five diagnostic and acute treatment centers in the two main metropolitan areas of the State.
3. We recommend that a committee of five, three of whom should be experienced psychiatrists, be appointed to reconsider and make recommendations as to the most effective location of the additional beds.
4. We strongly recommend that the five diagnostic and acute treatment centers be established wherever feasible in connection with the medical schools in the State of California. Optimum capacity of such units should be determined by community needs as determined by consultation with local agencies.
   a. Such units should provide facilities for complete psychiatric examination and treatment, including outpatient facilities.
   b. It is proposed that these five units shall have a close working relationship with the state mental hospitals and shall serve the functions of screening, treatment, research, follow-up, and personnel training.
5. We feel that the efficiency of mental hospital operations would be greatly enhanced by increasing the authority and responsibility of the medical superintendents; also that interdepartmental interference should be eliminated to the end that the Department of Mental Hygiene have greater autonomy with regard to determining its own needs.
6. We feel that the number of all classes of psychiatric personnel employed is so low that the safety and proper treatment of patients can no longer be assured. We recommend that the number of authorized positions in all classifications be immediately increased to meet the minimum requirements of the American Psychiatric Association. We feel that the nationwide shortage of psychiatric nurses precludes any possible hope of adequate recruitment in this classification. We suggest, as an alternative, that the Department of Mental Hygiene establish in each of its mental institutions a one-year program to train psychiatric nursing aides, who would work under the supervision of registered nurses with psychiatric experience.

7. It is recommended that an energetic nationwide recruitment program for hospital personnel in all categories be financed and put into operation at once.
8. Realizing that the medical director of each state hospital is in the best position to evaluate possible economies and improvements in services, we suggest that each superintendent submit in writing to the Director of the Department of Mental Hygiene his recommendations concerning personnel policies, admission and discharge procedures, the operation of any activities not intimately connected with patient care, and other matters upon which he may desire to comment.
9. We feel that one of the great difficulties in attracting psychiatrists to the state service is the marked inequity which exists between income in other psychiatric endeavors and the existing state salary scale. Since the success of our medical efforts requires an adequate staff of well-trained psychiatrists, we strongly urge an upward revision of salary scales.
10. We feel that salary levels of all other personnel should also be subjected to scrutiny and study. It is worth noting that increases in salary for personnel would represent the least expensive aspect of an improvement in our institutional program, and one which would bring immediate results in improvement of quality and numbers of personnel, and consequently in standards of treatment within our hospital system.
11. We recommend that the Legislature give favorable consideration to Senate Bill 608, which would permit qualified physicians and surgeons who are licensed in other states to work in our state institutions.
12. We feel that the traditional delegation of the function of commitment to the county and of treatment to the State should be revised. Our county psychiatric hospitals should be used as diagnostic and acute treatment centers wherever possible.
13. We recommend that all general hospitals become general hospitals in fact as well as in name by the establishment of wards for psychiatric and alcoholic patients. This recommendation regarding the hospitalization of alcoholic patients is in accordance with the recommendation of the American Hospital Association.
14. We strongly endorse Dr. Winfred Overholser's statement that the Director of the Department of Mental Hygiene should be a qualified physician with administrative experience; and we further recommend that this position be placed under civil service, with adequate salary, to ensure continuity and long-range planning.
15. We recommend that the Department of Mental Hygiene and its executive officer use every medium of public education to inform the people of California of the present condition of our mental hospital system, and of the proposed remedies which have come out of this Conference.

SECTION IV

THE MENTALLY DEFICIENT AND OTHER MENTALLY HANDICAPPED

Chairman: Dr. Tracy Jackson Putnam
Chief Neurosurgeon, Cedars of Lebanon Hospital, Los Angeles

Editorial Writer: Benjamin Bonapart
Superintendent, Homewood Terrace, San Francisco

Summary of Editorial Statement

The editorial writer opened the first meeting of this section with a statement of the problems in the care of the mentally deficient. He pointed out that we should not only evaluate our state program on the basis of the number of hospital beds available for the number of patients needing care, but we should also examine the situation of the mentally deficient child in the community in order to learn what needs cannot be met by families, schools, and public and private agencies. Then we can consider the necessary functions of the state hospitals and other facilities.

In defining the area for discussion, the difference between mental illness and mental deficiency should first be recognized. Several authorities agree that the concept of mental deficiency contains three essential parts: (1) marked limitation of intelligence due to (2) lack of mental development, rather than mental disease or deterioration, which is manifested in (3) social and economic incompetence. Between 1 and 2 percent of our national population are feebleminded. A still larger number who have only borderline intelligence do not fit into the regular public schools and are troublesome in their homes and communities.

He suggested that the section should devote itself to an examination of the whole problem in three areas: (1) identification and diagnosis, (2) treatment, training, and education, and (3) parent education and public education.

1. Identification and Diagnosis. Diagnosis is regarded as the function of the qualified psychologist, who can determine mental retardation through standardized tests. Emotionally disturbed and physically handicapped children often appear to be feebleminded, but after correct diagnosis treatment can sometimes be given which will raise performance to the level of their mental ability. Correct diagnosis is necessary before any plan can be made for the mentally deficient child and before any help can be given to the parents.

Mental retardation may, in roughly chronological order, be recognized by the pediatrician, the parent, the teacher, the social worker, or the psychiatrist to whom a referral may finally be made in a last desperate effort to get something done. We have no assurance that mental deficiency will be recognized early. There are grossly inadequate facilities, especially in rural areas,

for determining the degree of mental deficiency and the possibility of a child's responding to education and treatment; there is a deplorable lack of understanding on the part of parents of the problems of the mentally deficient child; and, finally, the general public is unaware that the mentally defective child may be capable of reaching some degree of self-sufficiency and usefulness to the community.

We should consider the advisability of registration of the mentally deficient.

2. *Treatment, Training, and Education.* We need further extension of school services for mentally deficient individuals and we must also plan for the child who does not fit into the school program but remains outside the scope of our present program of state care.

Skillful work with parents, to overcome their feelings of confusion and guilt or to help them meet their personal responsibility, is an essential part of any treatment plan for the mentally deficient child. Both public education as to the problems of mental deficiency and local facilities for individual help of parents are needed.

Very few social workers are adequately trained to work with the mentally deficient. This lack of trained personnel in the communities is a matter of grave concern. Services to the patient and his family may preserve the integrity of family life and provide the child with opportunities for security, growth, and self-reliance.

3. *Public Education and Education of the Parents of the Mentally Deficient.* There is not the time, the money, or the trained personnel to do the whole job of teaching parents how to live with and make a constructive life for their unfortunate children. There is frequent need for the use of adequate foster homes.

Public knowledge of mental deficiency is negligible. The misconception that most delinquents and criminals are mentally retarded is dangerous, since fears and reluctance on the part of business and industry to employ the mentally deficient seriously hamper efforts toward their rehabilitation.

Local communities are faced with the need to set up county programs for their own mentally deficient. California's population of mental defectives numbers between 85,000 and 100,000. There are now approximately 7,000 beds in state institutions. Under the new building program there should be a total of approximately 10,000 beds within the next three to five years. The public schools are equipped to absorb about 10,000 mentally deficient children and private schools are caring for less than 500. Can the social worker interviewing the distraught parent of a defective child offer any solution except placement in a state institution after long months of delay?

The development of a community education and treatment program depends upon several resources: community awareness of the need for loving care and sympathetic understanding of limited, handicapped children; the support of readily available professional advice and assistance; guidance clinic services; training facilities within local schools or agencies; and facilities for supervised play, available through local recreation or school departments.

Existing state hospital programs for mentally defective children reveal a startling quantitative inadequacy. Hence the focus in the hospitals has been

on "bulk" or "mass" handling, with consequent frustration of conscientious, trained personnel and frequent failures in treatment. In 1947 the Legislature granted appropriations for new buildings and expansion of existing facilities, but with our growth of population the need for institutional care has grown and plans are inadequate. We must not be denied the right to maintain high standards of professional and scientific service.

The State Department of Mental Hygiene is equipped to make scientifically accurate diagnoses. State hospital medical staffs cooperate in treatment on the assumption that harmful results of organic conditions may be modified and alleviated. Remedial teachers, psychiatric social workers, nurses, and attendants are trained for this highly specialized service. The hospital program is designed to take advantage of each patient's potential assets. The patient's capacity for work and his capacity for learning to read and write are determined. Attention is paid to problems of emotional confusion, retarded physical development, infantile habit patterns, and asocial or antisocial behavior. However, the Department is gravely limited by overcrowding and lack of staff in following this program.

We need to consider how children may be prepared for return to their families or for placement in foster homes, and how we can prepare families and communities to receive their children. We also need to inquire whether all of our mental hospitals for the mentally deficient are geared for both long-term and short-term care.

As the basis for discussion, the editorial writer then suggested certain recommendations, which would be directed toward an ideal program for public and private care of the mentally deficient and other mentally handicapped which also would be practical and realistic.

Following these introductory remarks by the editorial writer, the section chairman formulated briefly the special problems in epilepsy and cerebral palsy.

Epilepsy is a condition characterized by periodic convulsions or other seizures. These may include outbursts of irrational or destructive conduct. Epilepsy affects approximately one in every 200 of the population. Two main forms are recognized: the idiopathic form, apparently hereditary; and that which results from a destructive disease or damage to the brain. According to California law, it is mandatory that all cases of epilepsy be reported.

Seven hundred and twenty-four patients were admitted to the California state hospital system with the diagnosis of epilepsy with or without complications in 1945-47. On a statistical basis it is estimated that there should be 7,000 cases of epilepsy in California, of which about 1,400 may require hospitalization.

Great strides have been made recently in the treatment of epilepsy, so that approximately 80 percent of new cases can be returned to economic life by proper treatment. However, facilities for the application of such treatment are scanty, at best, and there remain many patients for whom hospitalization is essential. Many patients requiring institutionalization are mentally deficient or paralyzed. Experience outside of California indicates that these patients are best treated in special colonies, rather than in hospitals for the insane; and that the discharge rate is higher and more is accomplished for the

patients if the institution is located close to a metropolitan center to facilitate research and supervision by consultant specialists. This was recommended in the Hamilton Report of 1943.

Several national and local societies are interested in the welfare of epileptics, and the most active is the National Society for Crippled Children and Adults.

Cerebral palsy is an inclusive term to cover a group of conditions in which an injury to the brain or spinal cord has occurred, usually before birth, or during infancy, with resultant disability. Some patients who suffer from cerebral palsy are mentally deficient, but the majority are normally intelligent, though seriously handicapped by lack of muscular control. Minor degrees of cerebral palsy interfere with a normal course of education. Other patients cannot take any place in economic life unless they receive special training and prolonged medical and surgical treatment, while still another group, although normally intelligent, is permanently incapacitated in the present state of our knowledge.

The number of cerebral palsied patients returned to economic life is proportional to the effort spent in rehabilitation. Special facilities are required to carry out the prolonged treatment needed and some provision should be made for hospitalization of the most serious cases, apart from the feeble-minded and insane.

The National Society for Crippled Children and Adults is attempting to establish treatment centers for cases of this type, but cannot be expected to take care of the problem alone.

Summary of Discussion

Several discussants pointed to the need for more general understanding of the fact that epileptic and cerebral palsied patients may be mentally normal and therefore present very different problems from the mentally deficient; that each group should be segregated from the mentally deficient and from each other; and that a treatment program should be geared to their special needs.

The provision of small treatment units near community medical, psychiatric, sheltered workshop, and rehabilitation facilities was recommended as more therapeutic than further building of larger units in remote rural areas. In fact, several of the discussants stated vigorous opposition to the present plan of building an epileptic colony at Porterville, pointing out that it would not only be extremely difficult to find a staff for such an institution, but that a hospital in such a remote spot would be practically without consultation from medical schools.

The value of urban location of facilities for all handicapped children was stressed. Housing shortages and remoteness from training and research centers hamper the recruitment of adequate personnel. In order for any treatment facility for the mentally handicapped to be utilized fully for medical education purposes, such facility must be in close proximity to medical schools.

It was agreed that a hospital program geared to treatment rather than custody involves inservice training, adequate salaries, recruitment of adequate

numbers of highly competent professional personnel, and continuous research. It was pointed out that even custodial care costs less if optimum medical attention is given to all patients.

It was pointed out that with the advances made in research and diagnosis in the problems of the mentally deficient, the epileptic, and the cerebral palsied, the areas of hope from results of treatment have been enlarged.

There was complete agreement as to the vital importance of early identification; adequate diagnosis; coordinated community planning; and special social service, training, and employment facilities for all handicapped persons. Training of general practitioners in sympathetic understanding and in adequate treatment methods of epilepsy is needed. A public educational program, through adult education, Parent-Teacher Associations, and other local facilities is essential. Too often the mildly troublesome or delinquent defective is ignored "because he can't help it" or thrust into a state hospital to get him out of the community and thus avoid the inconvenience of dealing with him. Only through adequate diagnosis can the child who is slow, emotionally disturbed, or who has special disabilities be distinguished from the mentally defective and given adequate help. The importance of providing diagnostic treatment and custodial services on the community level cannot be overemphasized.

Small treatment and study homes, well staffed, can provide facilities for treatment, research, and training. Family care homes (foster homes) can provide a constructive continuing experience for many children who cannot adjust in their own homes. If necessary, the State Department of Mental Hygiene should find and subsidize such homes.

The present program of the State Department of Education for special services to mentally deficient and cerebral palsied children is of great value, but its scope is severely limited by shortages of funds and of trained personnel. Extension of services to the secondary school level is lacking and should be developed. More adequate staffing of nursery schools for cerebral palsied children, provision of home teaching for the severely physically handicapped, and facilities for psychiatric consultation within the school systems are also needed for rounding out an adequate program.

After the mentally handicapped have received their maximum education and training, there are some who need to go out into the community and engage in some creative work but cannot work under competitive conditions. The advisability of developing sheltered workshops for this group was recommended for serious consideration.

Because of the significant contribution which parents' organizations have made towards parent education and other phases of the cerebral palsy problem, a recommendation was made that a similar organization of parents of the mentally retarded be encouraged. At the same time, it was pointed out that the total community needs to be educated, and not just the parents of the handicapped children.

There is an urgent need for better coordination of existing community facilities for diagnosis, treatment, and services for all handicapped persons and the State Department of Mental Hygiene should assume responsibility for assisting communities in these areas.

A real need was voiced for a clarification of the appropriate responsibilities of the several levels of administration—state, county, and city—in view of the overlapping of cases (for example, cases of cerebral palsy who may also be mentally handicapped), facilities, and jurisdictions. It was suggested, too, that there perhaps should be some uniform standards for referral of cases by the various counties to the State Department of Mental Hygiene.

An intensive program of research within state hospitals, medical schools, and community facilities will be of great value in the prevention and treatment of cerebral palsy, epilepsy, and mental deficiency. Such research will also provide a greater understanding of normal child development.

In view of the foregoing discussion, this section presented the following findings and recommendations:

* ***Recommendations for Immediate Action***

1. That the Governor appoint a continuing advisory committee to consider at length the objectives of this Conference.
2. That the section on Personnel be urged to consider and eliminate existing inequities in salaries of all personnel dealing with the mentally and physically handicapped, and to consider other inducements to facilitate recruitment of competent personnel.
3. That the following legislative recommendations be made:
   a. That Senate Bill 608, liberalizing the provisions of licensing state hospital physicians, be endorsed in order to relieve the critical shortage of properly trained medical personnel.
   b. That Assembly Bills 338 and 810, which undertake to limit the taxing authority of school districts in their programs for the education of the mentally deficient, be vigorously opposed.
   c. That Senate Bills 318 and 319, which expand powers of school districts and increase the amount allowed per unit of average daily attendance for the education of mentally retarded minors, be endorsed.
   d. That certain technical aspects of Senate Bills 318 and 319 be referred to a committee for immediate study and clarification.
4. That the authorized building program of the Department of Mental Hygiene to provide additional facilities be pressed and that another institution for mental defectives be authorized immediately in the Los Angeles metropolitan area since there is a 25 percent overcrowding in existing institutions and also a waiting list of 2,500.
5. That facilities be provided for an outpatient clinic in each existing institution for mental defectives, to give assistance in extramural care.
6. That each institution for mental defectives be provided with a general children's psychiatric unit of approximately 100 beds for the purpose of observation, diagnosis, and treatment of abnormal children, as defined in Section 740.5 of the Welfare and Institutions Code.

* In the interests of a more logical arrangement and a fuller statement, these recommendations are not in the same numerical order as they were in the Preliminary Report, which was rather speedily prepared.

7. That the plan to establish an epileptic colony at Porterville be abandoned in favor of the establishment of small hospital units adjacent to and affiliated with medical centers of education, to further teaching and research in the field of epilepsy and to facilitate establishment of greatly needed outpatient clinics for epilepsy.
8. That the Bureau of Social Work of the Department of Mental Hygiene be given additional staff and supply psychiatric social workers to work with the families of the vast number of patients on the waiting lists of the hospitals for the mentally deficient.
9. That the members of this section send greetings and best wishes to Mrs. Dora Shaw Heffner, expressing sincere appreciation for the many hours of untiring effort she has spent in the development and expansion of the program for the care and general welfare of the mentally retarded.

Recommendations for Long-range Consideration

Present facilities and existing plans for future building expansion will provide, under the state hospital program, for approximately 10 percent of the mentally deficient who need care. To provide for the remaining 90 percent, many of whom are in urgent need, this section proposes that the Governor appoint a subcommittee of the continuing committee to lay out a blueprint of an ideal mental hygiene program which will round out the institutions and facilities already in existence and will provide optimum services to all, at minimum cost to the State and maximum benefit to the patient, his family, and the community.

To this committee were referred the following proposals:

That colleges, universities, and medical schools further expand their facilities to provide theoretical and practical education to teachers, social workers, doctors, and psychologists in work with the mentally deficient and other handicapped and to provide extension work for inservice training.

That adult classes and other means of education be used to give the general public a greater understanding of mentally deficient and other handicapped children and adults and the ways for helping them to adjust as useful and productive members of the community.

That the State give financial support to public schools so that they can provide adequate training for all grades of defectives who can fit into a school program.

That parents be assisted in handling their mentally deficient and other handicapped children through adult classes, public education, and the organization of parents' groups for mutual service—group therapy and group instruction.

That the State provide adequate personnel and financial assistance for the establishment of family care homes for mentally deficient and other handicapped who cannot adjust in their own homes but who do not need institutional care; and that the board rates allowed by the State

for the care of deficient children in family care homes be substantially increased.

That sheltered workshops, partially self-sustaining, be established under the Bureau of Vocational Rehabilitation.

That appropriations be increased for the establishment of outpatient clinics, to be staffed by psychiatrists, clinical psychologists, and psychiatric social workers, to provide diagnosis; make referrals for needed medical or surgical care; and give needed therapy and guidance to mentally deficient and other handicapped children and their families.

That further expansion of institutional facilities for the mentally deficient be directed toward segregation of different levels of mental defectives in different facilities; that only epiletics who are also mentally deficient be placed in institutions for the mentally deficient; and that individuals of borderline mentality be placed in institutions for the mentally deficient only when no other type of care is available.

That there be established immediately in the California State Department of Mental Hygiene a Department of Professional Services, adequately staffed and financed, to supply the greatest need in mental health—trained personnel skilled in the application of modern treatment methods. This department would perform the following functions:

1. Recruit and expand manpower facilities for both preventive and curative work in mental health throughout the State.
2. Encourage and foster research.
3. Carry on continuous inservice training in hospitals, training schools, and clinics to provide proper care and to get patients out of these institutions as soon as possible.
4. Carry on a campaign of public education in the field of mental health and foster a more adequate program of family care community services.
5. Develop techniques for the proper handling of patients in and out of hospitals, in training centers, and in outpatient clinics.
6. Provide uniformity of treatment, care, and understanding of patients and their personal and family problems.

That all state institutions for the mentally deficient and other handicapped be given the personnel, facilities, and appropriations necessary for the provision of a continuous research and intraining program, adequate study and diagnosis, all needed medical and psychiatric treatment, and optimum educational and vocational training and job placement, to the end that every patient shall be helped to adjust, in the institution or in the community, at the highest level of his capacity.

SECTION V

MENTALLY ABNORMAL OFFENDERS

Chairman: William B. McKesson
Judge, Superior Court, Los Angeles County

Editorial Writer: Dr. George Tarjan
Director of Clinical Services, Pacific Colony

The editorial writer of this panel emphasized in his preliminary statement that the problem of the mentally abnormal offenders is difficult and complicated. He stated that the panel should not only plan for the disposition of the so-called "incurable criminally insane" but also attack the entire problem with hope and optimism. He emphasized that from the psychiatrist's point of view all offenders represent mental abnormalities, but warned the panel against broadening definitions without providing appropriate programs for the psychiatric care of the additional offenders.

He described the differences between the concepts of the legal minds and the psychiatrists. He stated that the psychiatric approach is based on the idea of treatment, cure, and prevention, and includes early diagnosis, complete re-education of mild cases, and intensive treatment of the more severe ones. He emphasized that extensive research in this field is essential and that all future programs must be centered around the possibility of such research. He described the existing laws concerning the criminally inclined insane, the sexual psychopath, the defective or psychopathic delinquent, and the drug addict, and suggested that the laws be examined from the point of view of both the offender and society. He also stated that the problem of the neurotic offender, the offender with borderline mentality, and the "adult" psychopathic offender should be studied, in addition to the possible re-evaluation of the present California "right or wrong test," and closed by stating that only through cooperation between all agencies could there be real progress in this field.

Discussion clearly indicated the differences in basic thinking between representatives of the varied schools of thought who participated. For instance, the psychiatrists felt that more could be achieved in the future by psychiatric treatment of offenders in general, and that society would be better protected by an attempt along those lines. The representatives of law enforcement agencies felt that the first obligation of all concerned must be the unquestioned guarantee of safety of the general public, even though that may mean prolonged incarceration of offenders.

The group felt that the present intention of the law is to handle most mentally abnormal offenders on the presumption that they are primarily "offenders" and, therefore, to place most of them under the jurisdiction of the penal authorities of the State. Psychiatric treatment should be assured by increasing the psychiatric facilities of the institutions under the jurisdiction

of the Adult Authority and the Youth Authority. It was generally agreed that offenders should be sent to the facilities of the Department of Mental Hygiene only when that Department can offer better care and treatment than the other facilities, but that the Department of Mental Hygiene must first be given an opportunity to fully develop its own plans for the treatment of these offenders. It was unanimously agreed that the facilities of all agencies—the Department of Mental Hygiene, the Adult Authority, and the Youth Authority—are inadequate and must be greatly enlarged as to housing and personnel before much improvement can be expected.

The group was in definite agreement that the treatment of offenders is still in the experimental stage, and therefore an intensive program of research is necessary. Most discussants voiced dissatisfaction that no concentrated research program in this field has ever been carried out by any agency in the State of California. It was felt that research should be directed toward the development of better methods of prevention, early diagnosis, treatment procedures, and the establishment of better standards in the determination of improvement and cure. It was felt that such research programs under the leadership of the psychiatric profession should solicit the help of professional workers such as educators, sociologists, psychologists, penologists, criminologists, and of others who could contribute substantial assistance, such as members of the clergy, parents' organizations, and interested lay groups. It was emphasized that an aggregation of specialists in these diversified fields is available only in urban areas and in the vicinity of such known centers of education and research as universities.

Great fear was expressed by speakers representing different communities that known abnormal offenders, particularly sexual offenders, are at large in society. They are apprehended following an unusual crime and then returned to freedom without any treatment, if they are not found guilty of committing that particular offense. It was suggested that if any individual is justifiably believed to be predisposed to the commitment of such offenses, he should be given the opportunity of treatment before he commits a serious antisocial act.

It was agreed that even though there is no imperative need for the revision of a number of the existing laws, these laws should be re-evaluated and clarified, so as to prevent different interpretations by the many agencies involved and consequent needless movement of offenders from one agency to another. It was specifically recommended that the laws pertaining to "defective and psychopathic delinquents" be re-evaluated with this suggestion in mind. Most people felt that a definite and final determination should be made as to which agency should care for each type of offender, and that each agency should be required to make plans for the treatment of the offenders under its charge.

It was felt that the present laws pertaining to "sexual psychopaths" need improvement. It was recommended that the defense of not guilty by reason of insanity, based on the "right or wrong test," should be further studied and re-evaluated. Opinions were expressed that provisions should be made, by the enactment of laws and particularly by the provision of facilities, for the care of the "neurotic offender," the "adult psychopathic offender," and the "offender with borderline mentality," because there is an unusual risk of

relapse if such offenders are returned to freedom without considerable treatment.

Several opinions were voiced by representatives of communities that the average smaller community in the State is able to obtain no help or very little help from anyone for the work of prevention, early diagnosis, and treatment of mild cases. Because of this situation, many children and adolescents grow into serious offenders. It was thought that greatly increased sources of scientific assistance in the form of child guidance clinics are needed for the school systems. It was agreed that additional outpatient clinics "available to all communities" would assist in the treatment of juvenile offenders and in the better orientation of parents, and could offer treatment to individuals with mild antisocial behavior before serious crimes are committed. The need was voiced for vastly increased facilities for child psychiatric care all over the State. The shortage of all types of trained personnel, particularly physicians trained in psychiatry, is partly responsible for the lack of available assistance.

It was the consensus of the group that only a better understanding of the dynamics of antisocial behavior and the cooperation of all concerned in planning and working with offenders can offer the hope of real progress in this field.

The panel, therefore, makes the following recommendations:

1. That the problem of the mentally abnormal offender presents many unknown qualities which can best be solved by an intensive research program. It is felt that such a program would justify itself by producing new methods of treatment and would result in the rehabilitation of a large number of mentally abnormal offenders. It is also recommended that the medical schools of the State be urged to lay more emphasis on the acuteness of this problem and further improve psychiatric training through such steps as increasing the number of students and graduates trained in psychiatry, and adding beds to their teaching hospitals specifically for the study of mentally abnormal children. It was further recommended that the medical schools be encouraged to find means to increase the number of students in training.
2. That there is an immediate need for a maximum security hospital under the jurisdiction of the Department of Mental Hygiene which should be the home of intensive research and training, and, therefore, should be located near a metropolitan area where added medical research facilities are available.
3. That the present facilities for the care of mentally abnormal offenders under the jurisdiction of the Department of Mental Hygiene, the Adult Authority, and the Youth Authority, be immediately increased as to buildings, treatment facilities, and personnel.
4. That outpatient clinic facilities be provided in existing and future institutions to help in the early detection and treatment of mild cases of mentally abnormal offenders.

5. That help be furnished to small communities and school systems by the establishment of clinic facilities to aid in the early detection and treatment of mildly abnormal children.
6. That the Youth Authority and Adult Authority be provided with adequate facilities for the psychiatric care and rehabilitation of the offender with borderline mentality.
7. That the Youth Authority and Adult Authority be provided with facilities for the psychiatric care of the "adult psychopathic offender" and the "average psychopathic juvenile offender."
8. That the Governor appoint a committee of not more than seven persons, including at least one judge, one district attorney, one practicing attorney, one psychiatrist, one penologist, one educator, and one psychologist:
   a. To determine a proper definition of the term "insanity" as used in the criminal law;
   b. To determine a proper definition and interpretation of the term "defective or psychopathic delinquent" and its reconciliation with Section 7050 of the Welfare and Institutions Code;
   c. To devise means for disseminating modern and pertinent information regarding the problems of mentally abnormal offenders;
   d. To assist in formulating plans for research.
9. That the Sexual Psychopathic Act be amended to accomplish the following results:
   a. That the definition of sexual psychopath be redrafted so that it is understandable and definite. (A small committee should be appointed for this purpose.)
   b. That the act be made applicable only to persons charged with sex offenses.
   c. That the act be made to apply only after conviction of the offense charged or an included offense.
   d. Authorize the court to suspend sentence and commit to the Department of Mental Hygiene for placement in a state hospital the defendant found to be a sexual psychopath who would benefit by hospitalization for treatment not available in the penal institution to which he would otherwise be sent.
   e. Provide that when the superintendent of the state hospital is of the opinion that the defendant is so improved that he is no longer a menace to the health and safety of others, or when the superintendent is of the opinion that the defendant's psychopathic condition is such that it will not be further benefited by treatment in the state hospital and that he is still a menace to the health and safety of others, the superintendent shall so certify to the court, and the court shall forthwith order the return of the defendant to the court.
   f. Provide that if the superintendent of the state hospital has certified that in his opinion the defendant is so improved that he is no longer a menace to the health and safety of others, and the court, after

considering all the evidence before it, is satisfied that this is the fact, the court may place the defendant on probation for not less than five years, if he is otherwise eligible for probation; and provide that if the superintendent of the state hospital has certified that the defendant is in his opinion still a menace to the health and safety of others, the court shall impose and shall not thereafter suspend sentence; and provide that the time spent in the state hospital is not to be considered in determining the time to be served under the sentence.

10. That the problem of the mentally abnormal offender can be solved only with the cooperation of many agencies, societies, and organizations.

SECTION VI

PERSONNEL

Chairman: Dr. Norman Reider
Mt. Zion Psychiatric Clinic

Editorial Writer: John Fisher
Executive Officer, State Personnel Board

How can the mental hospitals achieve the goal of a competent staff trained in its duties, aware of its responsibilities, harmonious in its objectives, unified in its efforts, and happy in its environment? With this question the editorial writer opened the discussion of the section on Personnel.

More concretely, what should be the education and experience requirements for employees in the mental hygiene field? Are educational institutions gearing their courses to the requirements of the mental hospitals? Are state salaries adequate? Are potential employees being told about opportunities in state service?

The editorial writer described the expansion and strengthening of the skeleton of the State Department of Mental Hygiene since 1944 by the addition of key positions at strategic points in the organization: medical deputy director, director of nursing services, directors of clinical services, psychiatric nursing instructors, professional librarians, and others. Also, physical and occupational therapy was placed more firmly on a professional basis.

While the skeleton has been provided, many of the key positions remain vacant today. Further steps must be taken before there is at work a fully staffed and well integrated organization moving ahead in unison toward the accomplishment of its objectives. Of utmost importance is the procurement of the qualified personnel needed to fill out the staff. The editorial writer then discussed the problems involved in recruiting medical, nursing, and therapy staffs.

A nationwide shortage of psychiatrists exists, estimated at 10,000 to 14,000. Of these physicians available, why aren't the state mental hospitals getting their share? Is it because of the absence of adequate supervision and facilities for giving training in psychiatry? Is it because the location of hospitals in rural areas is not attractive? Is it because of the housing shortage? Is it because the State of California pays less than doctors make in private practice? While the Department expresses a desire to have its hospitals approved for a one-year residency, experience shows that the lack of achievement of this goal is keeping capable, ambitious young doctors out of state hospitals. It is clear that the number and quality of applicants for physician posts can be significantly increased through exploiting the opportunities for training and challenging experience that are latent in the hospitals.

Housing is a cantankerous and aggravating problem that must be considered in deciding the location of future hospitals.

With respect to salaries, the State Personnel Board is committed to the principle of paying prevailing rates, and at the same time maintaining a balance among related occupations within the state service. Most physicians are in private practice, and the Personnel Board has relied upon the rates paid by semipublic and public organizations to establish the state physicians' salaries. While state doctors are being paid rates as good as or better than those paid by most public agencies, they are below the rates paid by the Federal Government.

While the Department of Mental Hygiene and the State Personnel Board have been publicizing on a nationwide basis the opportunities for employment in state hospitals, the product being sold has not yet been made sufficiently attractive in a strongly competitive market to secure the personnel so urgently needed. The nationwide shortage of psychiatric nurses is estimated to range from 14,000 to 47,000. In recognition of the generally undesirable location of the hospitals from the nurses' standpoint, and the psychiatric aspects of the work which they perform, the salary range for nurses has been somewhat above the rate in general hospitals. Neither this nor an intensive recruitment effort, combined with a program of continuous examinations, has served to ameliorate the situation.

The further extension and development of the programs of occupational and physical therapy is an integral phase of the over-all efforts of the mental hospitals. Occupational therapy appears to be on a firmer footing than physical therapy. Stockton and Camarillo hospitals not only have had good occupational therapy programs, but they have been used as field training centers for the students majoring in this subject. Both factors (program and student training) have been important in causing graduates in occupational therapy to seek employment at these hospitals. With the programs of six hospitals now supervised by professionally trained occupational therapists, one can reasonably expect that qualified graduates will, to an increasing extent, find their way into the state hospitals.

In summing up, we find that the programs and staffs of the hospitals in the state mental hygiene system have felt the combined impact of war-born shortages of professional workers and a materially increased patient population. The serious nationwide shortage will be alleviated only when the output of trained workers from our educational institutions overtakes the expanded demand. The problem that faces the state hospitals today is one of drawing out of the limited pool a greater quota of competent individuals with the requisite training and experience to fill out the framework that now exists. This can be accomplished by making available the opportunity for challenging and stimulating work, in an environment that encourages enterprise, and under employment conditions that are fair.

With these ideas as a background, the section then attacked the issues with a view to making service in state hospitals more attractive so that the objections to such service might be met, and the objectives of the Department of Mental Hygiene realized.

The findings and recommendations of the section on Personnel follow:

Reorganization

There was a great deal of discussion concerning the hospital administrative structure which indicated that authority, responsibility, and professional activity should be clearly delineated. *Lines of authority and staff relationships should be clearly defined with separation of clinical and administrative functions. It is also recommended that the superintendent of each institution establish an advisory committee consisting of the chiefs of various departments, such as psychiatry, nursing, occupational therapy, etc. Present trends in the theory and practice of hospital administration call ultimately for the placement of hospital administrative functions in the hands of specially trained hospital administrators, not necessarily doctors.*

Necessary new clinical and treatment units should be located in metropolitan areas in close geographical and physical connection to professional schools and training centers, facilitating the attraction of professional personnel into these units. Such a program will enable use of outside resources available in metropolitan areas. *Adequate facilities for training and research should be incorporated in the treatment program.* A medical school may, but need not, operate the new facilities. However, close integration and affiliation with the professional schools is desirable. *It is further recommended that affiliation of present state institutions with educational centers, using exchange of personnel and joint staff appointments, be encouraged.*

The Director of the Department of Mental Hygiene should have a more active professional advisory board. Similar boards should also be designated for each hospital. They should be consulted on general policy and specifically on training, research, and staffing. One of the consultants informally suggested that a number of specialty boards or committees be created, such as (1) medical treatment, (2) social services, (3) occupational therapy, (4) nurse and attendant training, (5) nutrition, (6) agriculture, and (7) public relations. One can reasonably expect improvement in quality of staff with use of such boards.

Until the day that each state hospital can have its full complement of clinical, teaching, training, and research teams at all professional levels, it is recommended that a system of part-time consultants and staff traveling from hospital to hospital be utilized.

Personnel Research

A fact-finding survey is recommended, to be carried on cooperatively by the Personnel Board, the Department of Mental Hygiene, the professional schools (medicine, nursing, social work, psychology, etc.), and various professional organizations, with the aim of eliciting from potential and present sources of personnel what conditions would have to prevail to make state service more attractive so that constructive changes may be made.

Professional Relationships

The general consensus is that *the training and experience requirements for service in the Department of Mental Hygiene should be constantly subject to review* and that *the Department of Mental Hygiene should strive to maintain the standards recommended by appropriate professional organizations and boards of standards. Any tendency to establish standards for state service separate and lower than those which are acceptable in general practice is to be deplored.*

A number of participants in presenting their opinions as to why state hospital service is unattractive to many professional workers indicated that one of the chief factors is the fact that state hospitals are set up with so much emphasis placed upon custodial care and so little upon treatment factors that doctors, nurses, social workers, and others are not attracted. This again points to the necessity of increasing treatment facilities in all institutions in order to attract personnel to carry out the treatment.

Personnel problems arise from lack of clarification of the interrelationships of clinical personnel. Nurses, social workers, therapists, and psychologists have been discouraged from entering state hospitals because their professional skills are not fully utilized in the treatment of patients and there is a tendency to relegate them to perform routine tasks. This lack of recognition on the part of state hospital administrators and psychiatrists must be overcome in order to attract and retain a sufficient number of able professional employees. *Duties and functions should be defined so that psychiatrists, nurses, social workers, psychologists, physical therapists, occupational therapists, recreational therapists, technicians, and attendants can work as a therapeutic team.* It was pointed out that the personnel team was the key to the treatment arch and should not be overshadowed by other considerations. Such integration will help to solve internal complications and simplify recruitment of professional personnel.

No single factor of salary, housing, retirement pay, social security, promotions, etc., seems to be the determining factor in desirability of position, although each plays its role. But along with the combination of these factors is the element of satisfaction in one's work, which cannot be overestimated. Numerous instances were given of positions being turned down because of lack of clarity in status and duties, too much responsibility, lack of opportunity for promotion without stepping out of a professional role, etc. *There should exist equal opportunities for advancement and compensation in both professional and administrative fields.*

It is recommended that civil service and professional qualifying boards make more use of unassembled examinations and more thorough investigation of qualifications as criteria for professional competence.

Further Aids to Recruitment

Appropriate recognition should be given to the role of the institutional attendants who form the great bulk of personnel actually in touch with patients. *It is recommended that as soon as feasible higher standards of training and experience for attendants be established;* and the State should be

encouraged to draw upon the experience of the National Mental Health Foundation in the attendant field.

It is recommended that use be made of "Institutional Service Units" along the lines demonstrated by the American Friends Service Committee to develop interest among college students so that they may be attracted to state service upon graduation. To the same end, positions as attendants should be established for the temporary or part-time employment of college students in state hospitals under proper supervision.

It is also recommended that the state hospitals establish student aid positions which would furnish room and board and a stipend to college students being trained in fields relating to mental hygiene.

In order to attract qualified personnel a systematic and constructive program of public education in the mental health field is indicated.

Repeated mention was made of the lack of a public education program by the Department of Mental Hygiene. *The press, radio, movies, and other public information media should be utilized both for preventive mental hygiene and to keep the public informed on the program of the Department. Sustained public interest in the mental health problem, rather than sporadic sensational news stories, should be stimulated by the Department.*

A lack of respect for the state hospital program by many members of the public and professional groups prevents many persons from seeking employment in state hospitals. Real understanding by the public will bring respect for the objectives of state hospitals and should result in more interest on the part of qualified personnel in working with such a program.

It is the opinion of this section that whatever budgetary increases are necessary for the accomplishment of the above recommendations are justified.

SECTION VII

ADMISSION AND RELEASE PROCEDURES

Chairman: W. Turney Fox
Judge, Superior Court, Los Angeles County

Editorial Writer: Gardner Bullis
Chairman, Legislative Committee, Mental Hygiene Society of Northern California

This section included discussants from all of the groups concerned with the problems of admission and release of patients—judges, lawyers, probation officers, psychiatrists, doctors, educators, social workers, health officers, peace officers, a private sanitarium manager, and representatives from the State Departments of Finance and Mental Hygiene. Governor Warren was present for a considerable time during one of the sessions. Participation in the discussion was widespread, with agreement on many basic ideas and real division of opinion on others.

The editorial writer opened the first session with the statement that this section was concerned with broader problems than "how they shall take the patient into the hospital and take the patient out."

He reviewed the present admission procedures in California:

1. Voluntary admission (Section 6602, Welfare and Institutions Code, under which about 1,000 patients were admitted during the 1947-48 Fiscal Year);
2. On application of a local health officer with two physicians' certificates (Section 6610, et seq., Welfare and Institutions Code, under which 342 patients were admitted since the law went into effect in 1947);
3. Court commitment after petition and on recommendation of two physicians (Section 5047, et seq., Welfare and Institutions Code, under which about 9,000 patients were admitted during the 1947-48 Fiscal Year).

The editorial writer stressed the need to integrate admission and release procedures with the treatment program for the patient and suggested consideration of several questions: evaluation of court procedures and practices; consideration of strengthening the health officer certification plan by removing the numerous checks and balances which were originally intended to prevent possible "railroading," but in practice have left this plan little more than a method of voluntary admission "with official blessing;" the present method of transporting patients to the hospital by police officers or sheriffs; increased use of social workers in securing case history material for the use of medical examiners preliminary to the court hearing, in serving as "the contact between the court, the institution, the patient and his family," and in providing continuous counseling service aimed toward an intelligent release

program benefiting both the patient and his community; and re-evaluation of release procedures relating to sex psychopaths.

Most of the discussion concerned admission procedures. There was free consideration both of specific issues and of the philosophy underlying existing practices.

Early in the first session the editorial writer recommended that all the provisions of the Welfare and Institutions Code as they apply to court commitment procedure be repealed, and that the health officer certificate plan be strengthened with provision for petition to the court after arrival at the hospital, similar to the plan now used in Maryland. Discussion of this proposal revealed general agreement on most points, but a marked difference of opinion regarding the question as to whether court hearing should precede or follow hospitalization.

There was complete agreement that the diagnosis of the patient's illness is a medical problem and should be the doctor's responsibility. It was also agreed that all patients have a right to immediate medical treatment, but that in arranging the treatment of mental patients provision must be made for the preservation of civil rights of patients and the protection of the community. For that reason it was the consensus of the group that court procedure relating to the mentally ill should not be entirely eliminated.

There was lively debate in relation to these legal and community aspects of admission. A number of discussants were in favor of retaining the present court commitment procedure with certain modifications, since they felt that in this way the legal rights of the mentally ill person could best be safeguarded. The person presumed to be mentally ill frequently needs the protection of the law to prevent "railroading" and insure protection of his estate. The determination of whether a person is mentally ill is primarily a question for the medical profession. However, doctors do sometimes disagree on whether or not a person is mentally ill, and the judge has to make the decision. Also, an order by the court is often needed so that the patient may be taken into protective custody for examination and later transported to the hospital.

From the discussion on the previous point, there was unanimous agreement that without changing the essential character of court commitments, several modifications could be made in procedure which would better serve the medical needs of the patient while still protecting his civil rights. Open court hearings and the patient's personal appearance in court are not essential. It is not necessary to have relatives and friends testify as to the patient's condition in his presence. It should not be necessary to send uniformed officers to take the patient into custody. Early treatment could be provided by eliminating the five-day waiting period and giving the judge discretionary power to set the hearing at a time best suited to the medical needs of the patient. The patient's rights could be further protected by increasing to 30 days the time in which he or other interested parties can petition for a re-hearing on his mental condition. Whenever possible, a medical opinion of the patient's condition should be required to accompany the original petition, and psychiatrists should be appointed as consultants to the court.

Some discussants pointed out that only six states now commit on certification of two doctors, and two of these states also require certification by the judge. In contrast, 23 states follow court commitment procedures similar to those in California.

It was suggested that since the constitutionality of the health officer certification plan has not been tested in California, no radical changes should be made at this time. Removal of the power of the local health officer to veto the patients' hospitalization under the health officer certification plan would in essence make it a commitment plan without court protection and might result in patients being hospitalized without proper safeguarding of their civil rights.

Another group of discussants recommended a more complete revision of the whole commitment procedure, so that patients might be treated as ill people and not as criminals. This group urged that California adopt a plan similar to the Maryland statute, which provides that a person may be confined to a mental institution on application by a relative and certification by two psychiatrists that the person is mentally ill. The statute further provides for recourse to the courts if the patient or his family requests his release when the hospital staff considers him in need of further detention.

This group also favored the strengthening and wider use of the California health certificate plan. They pointed out that in the past the mentally ill person was handled like a criminal; was considered incurable; and, since adjudication of mental illness meant deprivation of civil rights, his legal protection was the prime consideration. But now, with increased knowledge of the causes of mental illness and the development of improved treatment methods, the large majority of patients can be cured completely or can be restored at least to adjustment in the community. This fact forces us to consider admission procedures geared into a program of cure rather than custodial care.

The mentally ill person should not be subjected to the emotional strain and the stigma of being brought into court. To the average person this has the connotation of being charged with a crime, regardless of the humane attitude and procedures of the court. Families already distressed by the illness of the patient should not have to bear the added burden of filing a petition and testifying to the patient's condition in court. The trauma of the whole court process can seriously interfere with the patient's later ability to benefit from treatment.

Proponents of the Maryland plan suggested that there are several ways in which the patient's civil rights can be protected under a commitment procedure based upon medical diagnosis and medical considerations. Court adjudication within a specific time after the patient is hospitalized can be required. At this hearing, the opinion of the hospital staff regarding the patient's condition can be made available to the court. The right to request a court hearing at any time by the patient or his family would provide further safeguards of the patient's rights. In addition, the right to petition for a writ of habeas corpus always exists and is a further safeguard.

Under the present court procedure of most California counties, the property rights of mentally ill persons are not considered in relation to the petition

for commitment. A separate hearing is held by the Probate Court, to determine whether the assets justify and warrant guardianship.

It was suggested that prompt hospitalization of the patient where he will get immediate care and treatment is no greater deprivation of his civil rights than placement in the psychopathic ward of a county hospital or in a jail pending a court hearing, while delay in hospitalization may be very harmful to his mental condition.

Governor Warren, who was present during a part of this discussion, was strongly interested in it because of his experience as a district attorney and his work over many years with the Legislature on this problem. He expressed understanding of both points of view; the one stressing civil rights, the other emphasizing mental health and care. He said that court jurisdiction over the rights of our people is essential, that we have made some progress in improvement of admission procedures, and that the health officer certification law may afford some further progress. He hoped that some means might be found to facilitate admission of patients to the state hospitals without sacrificing any of their fundamental rights.

This discussion led to the conclusion that certain changes in court procedure are necessary and that wider use of the health officer certification plan should be encouraged.

From the entire exchange of views it became evident that many sections of the Welfare and Institutions Code should be simplified or changed. Several specific questions raised during the discussion clearly pointed to this need: First, why is it necessary to have so many different types of admission for different diagnostic categories, if what all the patients need is psychiatric treatment? Second, why is there no provision for commitment of "sexual psychopaths" until they have been charged with a crime? Third, what methods can be found to provide potential sex offenders with early treatment?

The remainder of the discussion related to release procedures. There was very little conflict regarding these, and it was generally agreed that for the most part the release procedures now provided by law give adequate protection to the legal rights of patients. A question was raised, however, as to the legal rights of patients discharged as improved.

It was also generally agreed that our procedures for the release of sexual psychopaths should be changed in order to provide greater protection to the community. There was considerable discussion as to whether this section should make specific recommendations, or merely a general statement on this point. Since the section on the Mentally Abnormal Offender was considering this specific problem, it was finally agreed that a general statement from this section would be sufficient.

It was felt that leaves of absence from the hospitals should be encouraged as widely as possible, with the provision of adequate social services by the Department of Mental Hygiene.

Wide extension of the foster home program under social service supervision was suggested, and also the provision for an intermediate type of institution where convalescent patients could be prepared for return to the community.

Committing courts sometimes re-commit patients who are on indefinite leave of absence because their records do not show that the patient is still under commitment. It was suggested that the hospitals notify the committing courts when leaves are granted. It was agreed that this would be an administrative procedure, and would not give courts any privilege to veto leave plans.

The final problem discussed was the discharge of patients judged mentally ill at the court hearing, but then placed in private sanitaria or allowed to remain in their own homes under the supervision of the mental health department of the psychopathic court. It was pointed out that the California courts have ruled that a proceeding for hospitalization of a mentally ill person in a state or private hospital or sanitarium does not amount to an adjudication of incompetency. However, title companies do interpret it as such, and there is need to provide a method of release of such a patient which will protect his competency to transfer property and carry on other business activities.

In the light of the entire discussion, this section offers the following findings for consideration of the Conference:

Mental illness is primarily a medical problem, but does involve legal considerations. The mentally ill person is entitled to the same access to medical care as any other patient. However, procedure relating to hospitalization of the mentally ill person involves three important factors which must be reconciled in the interest of the patient:

1. The care and treatment of the patient.
2. The civil rights of the patient.
3. The protection of the community.

Our laws must be designed not only to protect the mentally ill person from pressures and procedures which will aggravate his condition or be a detriment to his recovery, but also to protect his civil rights.

This section makes the following recommendations regarding admission procedures:

1. That the three present forms of admission (voluntary, court commitment, and health officer certification) be retained and that the provisions of the Welfare and Institutions Code relating to court proceedings be amended as follows, so as to make treatment available to the patient as expeditiously as possible:
   a. Amendment of Section 5050.8 and related sections to eliminate the five-day waiting period and to give the court the discretionary power to fix the hearing at the earliest possible date consistent with the rights and best interests of the patient.
   b. Amendment to permit a re-examination of the patient's mental condition within a period of 30 days, upon the request of the patient or other interested persons.
2. That all petitions to the court for the examination of one assumed to be mentally ill shall include a statement from a licensed physician indicating the necessity for court hearing except where for good cause shown such requirement may be waived by the court.
3. That Section 5000 of the Welfare and Institutions Code be amended so as to provide that whenever possible the judges appoint as their

advisers in the psychopathic court, physicians who have specialized in the study and practice of psychiatry.

4. That the taking of the patient into custody and his transportation shall be on the basis that the patient is ill and not a criminal.
5. That the health officer certificate plan of admission be amended as follows:
   a. So that such admission procedure may not be arbitrarily nullified prior to the patient's hospitalization, but that adequate provision remain for petition for a court hearing.
   b. That this plan of admission be extended to the veterans' facilities and private sanitaria.
   c. That the health officers shall administer this law, and that appropriate legislation be adopted to protect such officers in its administration.

This section makes the following recommendations regarding release procedures:

1. That the practice of granting leaves of absence from the state hospitals, consistent with the welfare of patients, their families, and communities, be widely encouraged and sustained by the provision of adequate social services by the Department of Mental Hygiene.
2. That appropriate legislation be adopted to overcome the presumption of incompetency, where questioned, of patients who have not been committed to state hospitals but who have been found by the court to be mentally ill.
3. That notice of the release of patients on leaves of absence be given by the hospital to the clerk of the committing court, together with the the condition of such release.
4. That the sexual psychopathic law be amended with respect to release of persons committed thereunder, so as to provide greater protection for the community against their possible future depredations.

This section makes the following general recommendation:

That a study be made of the provisions of the Welfare and Institutions Code relating to admission and release procedures for the purpose of clarifying and simplifying the same; and that the State Department of Mental Hygiene, appropriate professional organizations, the State Judicial Council, and the Code Commission be invited to participate.

SECTION VIII

PROBLEMS OF THE AGED

Chairman: William R. Harriman
Director, Rancho Los Amigos, Los Angeles

Editorial Writer: Dr. Alexander Simon
Assistant Medical Superintendent, The Langley Porter Clinic

This section recognized that the problems of the aged are of serious magnitude. Persons over 60 years of age comprised 9.4 percent of California's general population in 1920; 10.1 percent in 1930; and 12.4 percent in 1940. Of approximately 12,000 mentally ill people admitted to the California state mental hospitals in 1948, over 3,000 were more than 60 years of age. Such patients comprise more than a fourth of current admissions to California state mental hospitals (28 percent). Almost all of these are diagnosed as suffering from either senile psychoses or psychoses with cerebral arteriosclerosis. It is important to note that 8.4 percent of patients over the age of 60 admitted to California state hospitals die within one month of hospitalization, and that 40 percent die within one year of hospitalization. However, in view of the fact that almost 40 percent of the patients over the age of 60 admitted to state hospitals are discharged, many of them as improved, one must not assume the fatalistic attitude that their treatment is useless and their rehabilitation impossible. Most of the discussion in the section centered around possible solutions to these serious problems.

The importance of an adequate mental hygiene program, leveled at educating the public about the medical and psychological needs and problems associated with the aging process, was emphasized repeatedly. It was thought that such education should begin in the schools and continue throughout adult life. It was pointed out, however, that most young people are poorly motivated toward studying the problems of advancing maturity which do not yet have a personal meaning to them. Education should be leveled first at the group in whom the problem is real: the elderly people themselves and the friends and relatives who find it necessary to deal with them. The general public should realize the large number of aged in our population, and appreciate that they desire some share of attention, just as children and adolescents do. Physicians, nurses, attendants, and social workers all need education along these lines.

Until recently, many doctors have displayed little interest in the problems of chronic disease. But just as doctors have become increasingly aware of the psychological aspects of disease in general, so through education can they be interested in the psychological problems of the aging process. The discussants thought that all facilities of the State, including the county welfare departments, the State Health Department, and other agencies of State Government,

should foster and encourage the organization of local agencies in the community to carry on this educational program. Mental hygiene societies, adult education classes, parent-teacher association groups, community chests, churches, etc., should be asked to give all the necessary encouragement to such a program, emphasizing the importance that the individual assume as much responsibility as lies within his power for his own problems of aging. The family and relatives of sick elderly people are very important in this problem. They are intimately involved, emotionally and practically, since the burden of nursing care often falls upon them, particularly the women in the family group. They need guidance and support and opportunities to ventilate their anxieties.

There was little need to discuss the importance that every possible facility, public and private, be made available to all for the maintenance of physical health and the repair of physical defects before they become marked mental handicaps. Everyone agreed that this is of prime necessity, and is part and parcel of a broad public health program at both private and public levels.

It was recognized that opportunity for work is the crux of most of the financial problems of the aged. It was generally agreed that the use of chronological and arbitrary age limits to force people into retirement is not the best approach, although government and industry are often guilty of it. Industry feels that it is in business to make a profit, and if the elderly person is more of a handicap than an asset to an industry, it is not fair to burden the industry with him. There is also the very real problem that an elderly person with a physical or mental handicap may constitute an industrial hazard for which the company is responsible and liable, and under the present law such liabilities cannot be waived. There is no obvious solution to these problems. Further research and investigation are indicated so that standards for retirement may be based on a person's physical and mental condition rather than on calendar age alone. These standards should apply to government as well as industry.

The section believes that people who are unable to work because of physical or mental handicaps and people who are looking forward to retirement in the near future should be encouraged to develop hobbies and interests to take up their time; and that communities should be encouraged to develop public and private facilities for recreation, clubs, education, and hobby training for the older age group. Mention was made of such a center at the Yacht Club in San Francisco, which is proving extremely popular and beneficial. Extended use of the adult education departments in hobby training, which is already accepted in metropolitan communities like San Francisco and Los Angeles, should be extended to other localities in the State. Such a program would do a great deal to dissipate feelings of loneliness and isolation, and might help to solve some of the psychosomatic problems presented by the elderly.

Throughout the State, especially in the metropolitan communities, there are "family style boarding homes" which are licensed by the State as "foster homes for the aged." These homes may provide an ideal solution for a limited number of elderly people who are well enough to live in such a group and can afford this type of care, which enables them to retain some sense of

independence. So long as private and public facilities for appropriate care and treatment of physical ills are readily available, such a program would undoubtedly serve to keep many of the homeless aged from being committed to large custodial institutions. It is especially important that facilities for recreation, education, and hobby training be provided for this group. It is important, too, that the people in charge of such family style boarding homes be educated, if necessary by the State, concerning the physical and psychological needs of the aged.

There was considerable discussion about the advantages of developing a "home care" program similar to that which has been developed at Montefiore Hospital, New York City, in the care of patients suffering from chronic diseases of various kinds. In such a program the home is treated as an extension of the hospital environment. The patient is provided with opportunities for medical care, transportation, visiting nurse service, housekeeping service, occupational therapy, and social service. This would decrease hospital costs. Even more important is the fact that some patients who do poorly in the hospital may respond dramatically well in the environment of sympathetic and affectionate care in their own homes surrounded by attentive relatives. Careful social service investigation would be needed to ensure the success of such a plan, which is possible only when there is close rapport between the family and the patient. Members of such a family would need guidance and support, and the opportunity to ventilate their anxieties either to physicians or to social workers.

It is recognized that the majority of elderly people do not need hospital care, and that a large group of them who are now being hospitalized might not require it under such a program. In those rural communities where hospital and clinic facilities are not readily available, traveling clinics would have to be organized.

For those persons who show early signs of mental deterioration, but who are still not so sick physically or mentally that hospital care is necessary, and who, because of various emotional involvements, cannot be cared for in their own homes by their own relatives, foster homes might be found with the aid of social workers on the staffs of public or private agencies. These social workers should be considered part of a therapeutic team, together with the nurse and physician, and should be concerned with the treatment of patients on psychological and environmental levels. There should be enough social workers so that all of their time is not taken up with questions of eligibility, and they should be qualified to assume responsibility for appropriate treatment.

It was generally felt that if more medical and psychiatric diagnostic and treatment services could be made available in physicians' offices or in the outpatient clinics of general hospitals, many of the patients who are now being hospitalized might be treated as outpatients for long periods before hospitalization becomes necessary. This would, of course, be much better than expensive hospital care, and in those communities where such facilities are not available the organization of traveling clinics would be necessary.

In general, it was felt that elderly patients requiring hospitalization for physical or mental handicaps should not be isolated in institutional homes for

the aged, although it was recognized that in appropriate cases these homes could provide advantages of group living and opportunities for medical and nursing care, especially if the homes were geared to individual needs. In this connection it was emphasized repeatedly that such an institution should be built with a majority of single rooms, rather than be composed of large wards.

There was considerable discussion as to the wisdom of sending the majority of patients suffering from senile and arteriosclerotic psychoses to state mental institutions, most of which are situated many miles away from the patients' homes. It was emphasized that the dislocation of an elderly person from his home and family often does much to hasten his deterioration and early demise. The moves from home to general hospital, to county psychopathic ward, to state mental institution, are upsetting even to a young person, but more so to the elderly, who depend so much for the satisfaction of their needs on familiar objects, people, and surroundings.

It was felt that when funds and building facilities become available, public and private hospitals should be enlarged to provide units adjacent to the acute general hospital, which would contain a proportionate number of beds reserved for the physical and mental problems of old age. It was generally recognized that the majority of these patients do not actually require mental hospital care in the ordinary sense. Those who are depressed and dangerously paranoid can be committed to mental institutions when this is indicated. But for patients whose problems are essentially those of physical and mental deterioration, appropriate general medical care is the prime necessity. Patients located in treatment units adjacent to large general hospitals could be more easily visited by their relatives, and they could share a general rehabilitation program directed toward the problems of all chronic diseases. This plan would also serve the educational purpose of increasing the interest of visiting physicians and young resident physicians in training.

If such a program is carried out, and the burden of care of elderly mentally ill patients is removed from the state institutions to the county level, it is assumed that financial assistance should be provided by the State to approved hospitals in proportion to the services rendered. In those counties which would not have facilities to care for such patients, arrangements could be made on a cooperative basis with adjacent counties which have appropriate facilities.

There was considerable discussion about the need to clarify present methods of handling problems of county and state residence of individual patients, and the advisability of more clear and specific definitions of residence.

In the light of this discussion, the section on Problems of the Aged presents the following findings:

In order to understand the complexities of the problems of the rapidly increasing proportion of aged persons in our population, consideration must be given to the physiological, psychological, environmental, and economic factors involved.

There is insufficient preparation for the changes that come with old age on the part of the individual himself, his family, his employer, his community, and sometimes even his physician. The solution for the individual who has already been affected by the physical and psychological problems of advancing years depends upon the ability to reintegrate him into society, to

help him obtain proper medical care, to maintain his economic security, and to assist him in finding emotional satisfaction.

The present facilities for the care of the aged in voluntary and public general hospitals and state mental hospitals are inadequate.

A more positive approach should be adopted, making better use of existing facilities at local and state levels, and adding new facilities when needed, with emphasis on reducing the incidence of expensive hospitalization.

This section recommends that:

1. A general educational program be directed toward informing the public of the medical and psychological needs and problems associated with the aging process, in order to assist people in assuming more personal and individual responsibility for themselves and the care of aged relatives.
2. Private and public facilities be available to all for the maintenance of physical health and for the repair of physical defects before they produce marked mental handicaps.
3. Opportunities for work within the limits of the aging individual's capacities should be available in industry and government. Ways and means should be sought by which retirement could be based on the person's general physical and mental condition rather than on calendar age alone.
4. Communities be encouraged to establish and develop facilities for recreation, clubs, education, and hobby training for the older age group.
5. Encouragement be given to the development of more family style boarding homes (foster homes for the aged).
6. Increasing attention should be given to the development of educational and training programs for the individuals concerned in the operation of boarding and nursing homes and the care of patients in them.
7. More adequate provision be made, where necessary, in the way of visiting nurses, doctors, housekeepers, social workers, and transportation service to clinics for those living in their own homes or in boarding homes.
8. For those persons who are showing early signs of deterioration, foster homes suited to their needs should be found with the aid of social workers from public or private agencies.
9. More medical and psychiatric diagnostic and treatment services be made available in the outpatient clinics of general hospitals, in physicians' offices of local communities, and by cooperative effort of adjacent communities, if necessary. Where other facilities are not available, a traveling clinic should be provided.
10. Encouragement be given to the development of more homes for the aged with advantages of group living and provision for medical and nursing care, especially if such homes are geared to the needs of the individual.

11. Wherever feasible, voluntary and public general hospitals be enlarged to provide an adjacent unit containing an appropriate number of beds reserved for the physical and mental problems of old age, these to include the mentally deteriorated senile and arteriosclerotic patients who do not require mental hospital care.
12. In consideration of the local communities assuming responsibility for care of the mentally ill aged, financial assistance should be provided by the State to approved hospitals in proportion to the services rendered.
13. Counties which do not have facilities for the mentally ill aged should arrange care for them with adjacent counties which have approved facilities.
14. Further study is needed in the development of more suitable methods of handling the problem of county and state residence.

SECTION IX

ALCOHOLISM

Chairman: Dr. Milton Chernin
Dean, School of Social Welfare, University of California, Berkeley

Editorial Writer: Dr. Lester Breslow
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In his preliminary statement the editorial writer outlined the problem of alcoholism in California and presented the essentials of an effective program for control.

Alcoholism is a disease. Persons afflicted with this disease are known as alcoholics. The term "alcoholic" applies to intemperate drinkers. The term "chronic alcoholic" refers to those intemperate drinkers who finally develop definite physical and mental disorders from prolonged and excessive use of alcohol. These terms do not apply to the social drinker—the moderate user of alcoholic beverages who does not seek intoxication and does not expose himself to it.

Intemperate drinkers and chronic alcoholics are serious problems to themselves, their families, their communities, their state, and their nation. In 1947 the estimated number of such persons in California was more than a quarter of a million—71,000 chronic alcoholics and 212,000 other intemperate drinkers.

Each year more than a thousand alcoholics are admitted to our state mental institutions. During the three-year period ending June 30, 1947, there were 3,454 new admissions and 803 readmissions for alcoholism.

Death certificates for more than a thousand persons who died in California during 1946 listed alcoholism as a primary or secondary cause of death, or mentioned alcohol in connection with cirrhosis of the liver. Another 554 persons were killed that year in motor vehicle accidents involving intoxicated drivers.

In 1947, 24,478 persons in California had their drivers' licenses revoked or suspended in cases arising from drunk driving.

Statistics for the State as a whole on the number of arrests for drunkenness are not available. However, the Crime Commission on Adult Corrections and Release Procedures has gathered data from various local authorities which indicate that arrests for drunkenness are made in great volume, in many cities at a much higher rate than in cities of comparable sizes elsewhere in the United States; that "drunk arrests" constitute a serious problem to law enforcement officials not only in our large cities but also in cities of all sizes and in rural areas; that included in this large volume of arrests is an undetermined but sizeable proportion of offenders who are repeatedly arrested, sometimes 50 to 100 times a year; and that the direct cost of such

procedures to law enforcement and judicial agencies in California may easily total six to ten million dollars annually.

These facts indicate the magnitude of certain aspects of the problem of alcoholism. They do not touch on the role of alcoholism in unemployment, indigency, divorce, and disruption of family life.

In the main, alcoholism is now handled as a criminal problem in California. It is dealt with by the police, courts, jails, and prisons. Through these agencies the alcoholic is punished and, to some extent, cared for. Through these agencies the community is, to some extent, physically protected from the alcoholic.

The most common procedure is to arrest the alcoholic while intoxicated, hold him overnight, and release him in the morning. Then, the same day, or within the next few days or weeks, to arrest him again, hold him overnight, and release him.

This "revolving door" procedure is sometimes interrupted by a longer jail sentence and infrequently, for extreme cases, by commitment to a state mental institution. If the arrested alcoholic is obviously in need of medical attention, e.g., for injuries sustained during his "binge," he may be sent to a public hospital for emergency treatment. But no treatment is provided for the alcoholism itself.

Although alcoholism is handled primarily as a criminal problem, it spills over and becomes a problem for mental hospitals and for other public institutions. The hospitals of the State Department of Mental Hygiene are presented with more than a thousand alcoholics a year. In almost all instances, these are chronic alcoholics, with or without psychoses, in the late stages of the disease. For these patients, the Department at present can do little more than provide custodial care. Other public hospitals as well as private hospitals are disinclined to admit alcoholics for treatment. Those alcoholics who are admitted receive treatment for acute alcoholism, other acute conditions, and for treatment of injuries. A small number are cared for in private sanatoria established to treat the alcoholic who can afford expensive care.

Welfare agencies, both public and private, also become involved. These agencies provide food, clothing, and shelter for many alcoholics and financial and other assistance for their dependents.

Some alcoholics come to the attention of individual psychiatrists, mental hygiene clinics, members of Alcoholics Anonymous, ministers, and other individuals and groups which are interested in rehabilitation and in the prevention of chronic alcoholism.

From this brief review, some may conclude that in California we are doing little or nothing about the problem of alcoholism. This, of course, is not true. Much is being done and many millions of dollars are spent each year on the problem. Unfortunately, though, these efforts and these expenditures for police and related activities, for institutionalization in mental hospitals, and for welfare services, leave the greater part of the problem untouched. These efforts are not designed to reduce the incidence or prevalence of alcoholism, and they encourage the unwarranted belief that alcoholics are hopeless unfortunates.

Recently, however, several communities in California have taken steps to attack the problem constructively. In at least one county, Alameda, a program for the rehabilitation of alcoholics has been initiated. In San Francisco, an extensive report on the problem of alcoholism, completed in 1948, contains detailed recommendations for a program for that city.

Alcoholism is a disease, not a moral failing or a crime. As a disease which now impairs the health of more than a quarter of a million persons in California, it must be considered as a public health problem of prime importance.

Any effective attack on alcoholism requires that efforts be directed toward prevention and rehabilitation. With the application of existing knowledge and skills, as demonstrated by the Yale Plan Clinics, by Alcoholics Anonymous, and by other groups, many alcoholics can be rehabilitated and the later stages of alcoholism can be prevented.

The alcoholic is an all-around liability, to himself, his family, and his community. The job of prevention and rehabilitation is worth undertaking, if for no other reason than to protect valuable family and community assets and convert present family and community liabilities into assets.

The job of prevention and rehabilitation is not a simple one. Modern research indicates that alcoholism is associated with many different physiological, psychological, and social factors. For most alcoholics drinking serves, in part, as an insulation against daily problems of personal and social adjustment. However, the underlying problems differ in type and complexity. There is no single type of treatment applicable to all alcoholics. A number of types of treatment and rehabilitation are effective, depending on the individual case. Consequently, effective treatment does not lie exclusively within the province of the general practitioner, the psychiatrist, the social worker, the minister, or such organizations as Alcoholics Anonymous. Yet all these and other individuals and groups can play a significant role in treatment and rehabilitation.

The essentials of an effective program for control of alcoholism are those services and facilities necessary for prevention, treatment, care, rehabilitation, and research. Such services and facilities require the active cooperation of all agencies and professions concerned with the problem and continuous support by the general public. This cooperation and support must be based on an understanding of the problem and the objectives of the control program.

Preventive services are of three types: (1) services designed to prevent the later stages of the disease (chronic alcoholism) through early diagnosis, treatment, and rehabilitation; (2) professional and public education activities designed to achieve widespread knowledge of the nature of the problem, the dangers involved in intemperate use of alcohol, and preventive methods; and (3) mental health, social welfare, slum clearance, and housing programs, as well as other activities and programs which eliminate or reduce social and personal factors related to human maladjustment.

Since treatment and rehabilitation must be related to the individual alcoholic and his problems, adequate diagnostic and referral services are essential. A community clinic for alcoholics is usually suggested to provide these services. Such a clinic would screen patients, determine from medical, psychiatric,

and social service histories what treatment is indicated, and make the necessary referrals.

Outpatient services are for the intemperate drinker and the chronic alcoholic who offer promise of rehabilitation. Treatment and rehabilitation may be provided at the community clinic or by private physicians, Alcoholics Anonymous, appropriate social welfare agencies, religious bodies, or other individuals and groups.

Some alcoholics need hospitalization for acute alcoholism, other medical conditions, or injuries due to or accompanying alcoholism. Such inpatient treatment could be provided in general hospitals or, to some extent, in hospital facilities set up as part of the community clinic for alcoholics.

Chronic alcoholics who do not respond to treatment or for whom effective rehabilitation is unlikely require custodial care from time to time. Some authorities recommend special facilities, such as state, county, or municipal farms, to provide this care.

Alcoholics who are psychotic require care in hospitals equipped to treat mental cases.

There is great need for all scientific and professional groups concerned to participate in research on every aspect of the problem of alcoholism. Specifically, research is needed on the physical, mental, and social factors associated with alcoholism and on methods of prevention, treatment, and rehabilitation. More accurate data and statistics are needed to guide all workers in the field and to provide a basis for evaluating their efforts.

It has been proposed that two research centers be established in California, one in the north and the other in the south. Each center would consist of a 250-bed hospital, with facilities and services for medical, psychiatric, and related research on alcoholism.

There is an acute shortage of the trained, specialized personnel required for diagnosis, treatment, rehabilitation, and research. This is particularly true of psychiatrists and ancillary psychiatric personnel. Furthermore, there is the need to train all personnel in the special problems of alcoholism. In any constructive program special attention must be devoted to the recruitment and training of necessary personnel and to the provision of adequate salaries.

In the light of the foregoing presentation, how can we most effectively, speedily, and economically establish, develop, and maintain constructive programs for the control of alcoholism in California? What action should local, state, and federal governments take and what facilities and services should each provide? What should be the role of the voluntary health and welfare agencies and the professional societies? How should the activities of all agencies, public and private, be related and integrated?

In the main, the section members agreed with the outline of the problem of alcoholism as given in the preliminary statement. However, the discussion brought out several additional factors, revealed basic differences on some points, and elaborated upon many aspects of the statement.

All discussants agreed that the problem of alcoholism is of great and increasing magnitude. It was stressed that these statistics, e.g., the number of arrests for drunkenness and the cost of arresting and jailing drunks, give only

an incomplete picture of the extent of the problem. The "hidden alcoholics", those who never or very infrequently are arrested, make up a significant segment of the problem. There is reason to believe that the number of "hidden" alcoholics is increasing rapidly both in rural and urban areas of the State.

It was pointed out that, at present, the police are performing an important function in arresting the habitual drunk for his own protection and that of the community.

There was extended discussion of the fact that, in the main, alcoholism is now being handled as a criminal problem in California, and the related point that a few communities are now swinging away from this archaic, expensive, and hopeless method of handling the problem.

Alameda County's new program for the rehabilitation of alcoholics was presented. In brief, persons arrested for drunkenness will be sentenced to six months' confinement in a special rehabilitation center for alcoholics now being organized in the Santa Rita Branch of the Alameda County Jail.

One discussant questioned the wisdom of branding alcoholics as criminals through sentencing them to this long period of confinement, and also asked whether this procedure would not encourage the "floater system". It was recognized that many alcoholics would probably leave the county to avoid six-month sentences, but it was suggested that adoption of the same procedure by other counties would make the plan workable.

The need for long-term confinement for many alcoholics was pointed out, and it was suggested that alcoholics who have been arrested repeatedly might be given indeterminate sentences and placed, not in jail, but in a treatment facility similar to the one in Santa Rita.

The plan for an alcoholic rehabilitation program in San Francisco was described. This program is designed to concentrate on the incipient rather than the chronic alcoholic, and will be available to any person who wants help regarding his alcoholism. There will be an extensive outpatient clinic, and a tie-up between the clinic and all rehabilitation services of the community. Provision is also made for hospitalization for acute alcoholism and some type of institutionalization for chronic alcoholism. An educational program will be of great importance in conjunction with this type of program. One discussant recommended that, as part of such a program, the penal statutes and ordinances be abrogated and, in their place, laws be enacted defining alcoholism as a health problem, not a criminal problem. These new laws would be modelled after the existing venereal disease and tuberculosis laws, using the public health concepts of quarantine and treatment instead of the penal concept of incarceration.

The program recommended by the Los Angeles Council on Alcoholism was also presented. Under this program, which is designed to separate penology and therapy in the handling of the problem, the alcoholic would not be permitted to escape his responsibilities because he is an alcoholic, but he would be provided with treatment, care, and rehabilitation. A new division in the State Department of Mental Hygiene would be established to administer this program, which would include hospitalization rather than incarceration, provision for voluntary admission, social welfare investigation, and research. It was pointed out that Assembly Bill 1072 (1949 Legislative Session), now

before the Legislature, encompasses most of the recommendations of the Los Angeles Council on Alcoholism.

A number of participants discussed various elements considered essential to an adequate program for control of alcoholism; and the roles of Alcoholics Anonymous, social welfare agencies and workers, probation officers, and the police were described and their importance was stressed. It was agreed that educational programs directed toward both professional workers and the general public are essential for the development of any effective program.

There was disagreement as to the desirability of establishing state hospitals for alcoholics as part of a program for control of alcoholism in California. Yale University reports were cited, to the effect that other states have had unsatisfactory experience with such hospitals and that many states have discontinued them. It was pointed out that those state institutions were never given a fair trial, since they were not set up as part of an over-all program for control of alcoholism and were really operated as jails without proper medical approach. Proponents of the plan for the establishment of state hospitals for alcoholics favor the building of two such hospitals as part of a statewide program, one hospital to be located in Northern California and the other in Southern California. These hospitals, which would function largely as research and treatment centers, would supplement and be integrated with the activities of community programs and clinics throughout the State. Two bills, Assembly Bills 1054 and 582, have been introduced in the 1949 Legislature to provide for these two hospitals. Assembly Bill No. 1054 has been endorsed by the Governor's Crime Commission on Adult Corrections and Release Procedures.

On the basis of this discussion the section on Alcoholism presents the following findings:

First, the section agrees that the alcoholic is a sick person. As an illness which is now impairing the health of more than a quarter of a million persons in California, alcoholism must be considered a public health problem of prime importance.

Second, in California alcoholism is handled at present primarily as a criminal problem of concern mainly to the police, courts, and jails. The "revolving door" procedure, consisting of repeated arrests and jailings and releases, is an expensive and essentially futile process. These measures achieve nothing constructive for the alcoholics who pass through the hands of the police; they do not touch at all the greater number of "hidden alcoholics" whose behavior has not yet brought them into contact with the law enforcement machinery. Moreover, these criminal procedures encourage the unwarranted belief that alcoholics are hopeless unfortunates.

Third, a more realistic, constructive, and economical approach is based on the fact that, by the application of existing knowledge and skills, many alcoholics can be rehabilitated and the later stages of alcoholism prevented. The successes achieved by Yale Plan Clinics, Alcoholics Anonymous, and other groups have conclusively demonstrated the practicality of this approach.

Fourth, the objectives of a modern program are to prevent alcoholism and to rehabilitate alcoholics. The essentials of such a program include preventive services, diagnostic and referral services, treatment services (both outpatient

and inpatient), research, and education. These require the coordinated effort of many professional groups and governmental and private agencies. Public understanding and continuous support are basic to the success of the program.

In view of these findings the section makes the following recommendations:

1. Every appropriate local community should establish:
   a. A clinic which provides diagnostic, referral, and treatment services for alcoholics. Such a facility might be associated with a general mental health clinic or a general hospital, or might be separate. Its aim would be to prevent the late stages of alcoholism through rehabilitation of early cases. The clinic staff would screen patients, determine what forms of treatment are indicated, conduct rehabilitation and treatment services, and make necessary referrals to Alcoholics Anonymous, social welfare, and all other appropriate agencies.
   b. A facility for more prolonged treatment of alcoholics. Such a facility might well be a farm with adequate treatment services.
   c. A policy encouraging general hospitals, both public and private, to provide hospital care for alcoholics.
   d. Citizens' committees for education on alcoholism which would serve as informational, educational, and developmental centers.
2. The State of California should:
   a. Provide financial assistance on a matching basis to the appropriate local governmental jurisdictions for the establishment and maintenance of preventive, diagnostic, and rehabilitation services, as well as facilities for the more prolonged treatment of alcoholics.
   b. Stimulate the development of adequate, trained personnel with special orientation in the field of alcoholism.
   c. Expand fundamental and applied research by social and medical scientists into the nature, causation, and treatment of alcoholism.
   d. Encourage public education concerning all phases of alcoholism, including emphasis on family life education, and utilizing every effective medium and agency.
   e. Expand its facilities for treatment of alcoholism (both inpatient and outpatient) and for research and education concerning alcoholism.
   f. Designate an agency to carry out the above responsibilities of the State in the field of alcoholism.
3. The Federal Government should establish a grant-in-aid program for the control of alcoholism, similar to the programs for other important public health problems.
4. Professional societies should undertake the education of their members in their professional responsibilities to the alcoholic.
5. The legal profession should study and recommend changes in the penal laws affecting alcoholics to conform to the modern concept of alcoholism.

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